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	03/03/2026

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 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of 21 residents (R10) was free from involuntary seclusion, failed to ensure criteria was met for admission to the Secured Dementia Unit and failed to follow physician's guidance for resident's wellbeing to prevent a change in condition reviewed in a sample of 41.These failures resulted in R10, a cognitively intact resident with admitting diagnoses of Post-Traumatic Stress Disorder and Generalized Anxiety, to be admitted to the Secured Dementia Unit on 1/30/26 and remained in the unit until 2/26/26.These failures resulted in Immediate Jeopardy.The Immediate Jeopardy was noted to begin on 1/30/26, when the facility failed to ensure a resident was free from Involuntary Seclusion when a cognitively intact resident was placed in a Secured Dementia Unit preventing the resident from leaving. Immediate Jeopardy was identified on 2/26/26. V31 (Regional Director of Operations) and V32 (Regional Nurse Consultant) were notified of the Immediate Jeopardy on 2/26/26 at 3:15 PM. The surveyor confirmed by observation, interview and record review the Immediate Jeopardy was removed on 2/26/26, but noncompliance remains at a level 2 because additional time is needed to evaluate the implementation and effectiveness of the plan of correction. Findings include:The Dementia Unit Admission/Discharge Criteria Program policy, revised 10/2017, documents The Secured Dementia Unit exist to provide residents with cognitive or Alzheimer's/Dementia related diagnoses a safe and comfortable environment where staff has been trained to care for their special needs, Residents may be admitted based on the following guidelines: 1. Resident does not display disruptive behaviors such as repetitive yelling or calling out. 8. Does not display wandering that is not easily directed or poses a risk to the resident or others. May include but not limited to excessive attempts to exit the unit or facility.The Facility's 671 dated 2/24/26 documents they have a Dedicated Special care Unit labeled as Alzheimer's Disease and has 53 beds.R10 was admitted on [DATE] with diagnoses of Post-Traumatic Stress Disorder and Generalized Anxiety Disorder. R10 was transferred to the Secured Dementia Unit on 1/30/26. R10's record did not include an admitting diagnosis of Dementia/Alzheimer's Disease.The Brief Interview for Mental Status (BIMS) documents on 1/29/26 R10's cognition was moderately impaired and from 2/3/26 to present has been cognitively intact.The Preadmission Screening and Resident Review Level 1 dated 1/27/26, documents R10 did not have a Dementia or Alzheimer's Disease Diagnosis, and Level 2 was not required.V56's (R10's Family Physician) visit notes dated 12/30/25,10/31/25 and 8/22/25 documents R10 had been evaluated for Dementia and passed the given test. No diagnosis of Dementia or Alzheimer's Disease were identified on the visit notes.R10's Elopement/Unauthorized Leave Risk review dated 1/29/26, documents R10 has a . history of or verbalizes a strong desire to leave-yes. Is there a history of dementia? No.A Progress Note dated 1/30/26 documents to move resident to Secured Dementia Unit for high elopement risk.On 2/3/26, V54's (Psychiatric Family Nurse Practitioner) Progress Note documents R10 would benefit from and resident requests to be out of the unit. V54 stated R10 has taken on a role as a caretaker for the residents in the Dementia unit.On 2/24/26 and 2/25/26, R10 was observed in bed with the lights out and stated I told them (facility staff) I didn't want to be here (facility), so they put me back here (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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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(Secured Dementia Unit). I don't feel like it's right. I shouldn't be locked in here. R10 stated she had passed all her cognitive tests and was not going to leave the facility (elope). R10 did not participate in activities because I don't want to be with old people, and I can't stand to see them (cognitively impaired residents) like that. I'd rather be alone.On 2/25/26 at 2:50 PM, R10 stated she had not slept the previous night because another resident was crying, and staff did not help the resident. I was worried she was going to die, so I kept checking on her. On 2/24/26 at 11:18 AM, V55 (R10's family member and Healthcare Power of Attorney) stated My mom does not have Dementia or Alzheimer's. She lived independently until (Financial Power of Attorney) stole her house and sent her to the nursing home.On 2/25/26 at 9:45 AM, V12 (CNA/Certified Nursing Assistant) stated she has cared for R10 since she was transferred to the Secured Dementia Unit on 1/30/26. V12 stated R10 does not appear to be confused, has expressed wanting to leave the locked unit and go back to the general non-secured unit with the general population, although R10 has not attempted to elope from the unit or has not displayed exit-seeking behavior. V12 stated the only behavior R10 has exhibited was Anxiety. She doesn't need to be down here (Secured Dementia Unit).On 2/25/26 at 9:40 AM, R10 was observed to ask if anyone could take her outside to smoke. V23 (LPN/ Licensed Practical Nurse) stated It's past time. The scheduled mid-morning smoking time is 9:30 AM.On 2/25/26 at 10:55 AM, V23 (LPN/Licensed Practical Nurse) stated the residents smoking times were at 7:00 AM, 9:30 AM, 1:30 PM, 5:00 PM and 7:00 PM. V23 stated R10 is the only smoker on the unit and Down here (Secured Memory Care Unit) we try to stick to the times. We have to have some kind of schedule.On 2/25/26 at approximately 10:05 AM, V12 (anonymous staff member) stated V23 did not allow R10 to smoke this morning because she didn't ask to smoke until 9:40 AM, 10 minutes after smoking time. Staff deny R10 of her smoking privileges if she is late for the scheduled smoking time.On 2/26/26 at 10:52 AM, V54 (Psychiatric Family Nurse Practitioner) stated she had voiced and emailed her concerns to V1 (Administrator), V2 (Director of Nursing) and V20 (Social Worker) on 2/3/26 and 2/17/26 regarding R10's overall well-being, increased anxiety, as well as acting as being a caregiver to the other cognitively impaired residents by being in the Secured Dementia Unit and did not meet the criteria or benefit from being housed there. V54 stated she was told no that R10 was not being moved because she was an elopement risk.On 2/26/26 at 10:21 AM, V54 (Physician's Certified Medical Assistant) stated their office did not refer R10 to the facility. On 1/20/26, the facility called the physician's office and requested R10's records. V54 stated R10 did not have a Dementia diagnosis and the facility had called two times today (2/26/26) and requested the doctor to add a Dementia diagnosis code to R10's diagnosis lists.On 2/26/26 at 10:40 AM, V39 (Medical Director/R10's Physician) stated many residents experience delirium the first 24-72 hours of admission. They get confused from taking them out of their environment. If the referring physician says R10 does not have a dementia diagnosis, R10 doesn't have a dementia diagnosis. R10 did not have a Dementia diagnosis and did not meet the criteria to be admitted to the Secured Dementia Unit.Immediate Jeopardy Removal Plan:The Facility submitted its original Abatement plan on 2/26/26 at 4:10 PM.The Regional Office returned the Facility's Abatement Plan for corrections on 2/26/26 at 4:30 PM.The Facility submitted an Abatement Plan with corrections at 5:03 PMThe Facility's Abatement Plan was accepted on 2/27/26 at 8:42 AM.On 2/27/26 this surveyor confirmed through interview and record review the facility took the following steps to remove the immediacy:On 2/26/26, V32 (Regional Nurse Consultant) reviewed all residents residing on the secured unit for meeting placement criteria. 100% completed on 2/26/26 at 4:56 PM.On 2/26/26, the Interdisciplinary Team was in-serviced on abuse pertaining to involuntary seclusion. 100% completed by V31 (Regional Director of Operations).On 2/26/26, the Interdisciplinary Team was in-serviced on adhering to physician guidance. 100% completed by V31.On 2/26/26, the interdisciplinary Team was in-serviced on dementia unit admission/discharge criteria and program. 100% of all 23 residents residing on the secured unit had BIMS review completed by V20 (Social Services).BIMS are reviewed quarterly or as needed. 100% of all 23 residents residing on the secured unit had BIMS review completed by V20 and V40 (Regional Social Services Director) on 2/26/26.R10 removed from the secured unit. 100% completed by V20 on 2/26/26.Completion date 2/26/26

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F 0835 Level of Harm - Actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** :Based on observation, interview and record review, the facility failed to provide adequate administrative oversight to ensure the facility implemented their policies for protecting resident's dignity, be free of involuntary seclusion and restraints, accurately assessed residents and provided quality of care based on those assessments, services were provided to meet professional standards, ADL (Activities of Daily Living) cares were provided for dependent residents, medications were safely administered, infection prevention measures were implemented and appropriately utilized, staff were qualified and competent and maintained a safe/ clean/comfortable environment. These failures resulted in a facility-wide lack of supervision and care leading to residents experiencing a lack of dignity by being exposed to other residents, visitors and other staff members not involved in the residents care, lack of nursing assessments which led to a residents decline and resulted in hospitalization, involuntarily seclusion which caused psychosocial harm, residents received unnecessary medications and amounts of medications without a diagnosis or behaviors to indicate the need for those medications, untimely assistance with showers resulting in residents being left disheveled and a sense of being dirty, lack of assurance the right resident received the right medication, right dose, right route at the right time, and not providing a competent and trained staff to provide resident cares. These failures have the potential to affect all 67 residents residing in the facility. Findings include:The facility's Daily Census Report, dated 2/24/26, documents 67 residents reside in the facility. The Facility assessment dated [DATE]-[DATE], documents in Part 4 Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies Staff type include Administrator, Staff Development, Quality Assurance Performance Improvement, Infection and Control and Prevention, Environmental Services, Social Services, Discharge Planning, Human Resources and Compliance and Ethics. On 2/24/26 at 9:15 AM, V1 (Interim Regional Administrator) stated the facility has not had an Administrator for probably a year, year and a half. V1 stated Regional Interims have filled in during this time. R5 was not provided dignity by staff by not utilizing a privacy curtain prior to pulling down his pants and incontinent brief before performing catheter care. R27 was not provided dignity by closing the door to the hallway for wound care. V29 (Certified Nurse Aide/CNA) was standing while feeding R76 and repetitively called R76 honey and sweety. R51 was not accommodated with her toileting preferences to get her up in a chair to toilet to prevent constipation due to staff time constraints. The facility was not maintained, safe, clean and comfortable due to leaves being in piles in the hallway and dirty floors on multiple occasions. R58 was observed in his room, wearing a heavy winter coat and complained of his room being cold because his heater had not worked in awhile. R58 stated it had been reported multiple times and staff say maintenance will come fix it. V6 (Maintenance) stated he was not informed of the broken heater in R58's room. R48 and R1 stated their joining bathroom sink had been clogged for six months and were unable to wash hands after toileting or brush their teeth at the sink. This has been reported to the Resident Council as well. R48 and R1's sink were observed half full of water which was not draining. The Dementia Care Unit had two floor drainage metal caps which were not secured, and one had a screw sticking upward approximately one inch causing a tripping hazard. The ceiling tile in the common areas had water stains on ceiling tiles and dust hanging from ceiling vents. V6 stated the water damaged ceiling tile was from a roof leak a year ago. Staff can submit electronic work orders although V6 did not have access to a computer from a water leak in his office. R10 was admitted on [DATE], was alert and reported she wanted to leave the facility. On 1/30/26, facility staff transferred R10 to the Secured Dementia Unit to prevent elopement. During this time, R10 did not meet admission criteria to the Secured Dementia Unit, had no diagnosis of Dementia, took on a role as a caretaker to Dementia residents, wound not participate in activities because I can't stand to see them (cognitively impaired residents) like that and V58 (Psychiatric Family Nurse Practitioner) addressed verbally and via email with the Interdisciplinary (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Many	Team that R10 needed to be in the general population, had not stated she was going to leave and didn't meet requirements to be in a locked unit against her will, although the Interdisciplinary Team denied the transfer because of the elopement risk. R10 resided in the Secured Unit until 2/26/26 when Immediate Jeopardy for Involuntary Seclusion was identified. R9 had a Physician's Order and Care Plan documents to use a self-releasing seat belt while in motorized wheelchair, although R9 was unable to release the seatbelt when prompted. R6 was prescribed and administered an antipsychotic, although no behaviors were exhibited to account for the use of the medication. R7 was prescribed and administered three antidepressant medications for a diagnosis of Depression, although R7 had no behaviors to account for the use of the medication. The resident nor staff could verbalize why R7 was on three antidepressant medications. R11 was prescribed and administered an antidepressant and a medication for Bipolar Mania. R11's guardian stated R11 had been nonverbal, frail and did nothing except lie in her chair. R71's medical record documented R71 was sent to the Emergency Department for evaluation of wounds. The medical record did not document any further information including whether R71 was admitted , expired or went home from the hospital. R7 sustained a fall at the facility and new interventions were not implemented on the care plan. R10 was admitted on [DATE] with diagnoses of Post Traumatic Stress Disorder and Generalized Anxiety and was alert and oriented and. R10 stated she wanted to leave and was deemed to be a high risk for elopement therefore was transferred to the Secured Dementia Unit on 1/30/26. A Dementia diagnosis was added to R10's diagnosis list although there was no Physician's Order or supporting documentation to support the Dementia diagnosis. During an interview with R10's family physician, it was stated that R10 was tested prior to admission to the facility and passed testing and did not have a diagnosis of Dementia. R11 was admitted with diagnoses of Alzheimer's, Conversion Disorder with Seizures and Hypothyroidism. A new physician order documents a new diagnosis of schizoaffective disorder. The Psychiatric physician's note did not mention a new diagnosis of schizoaffective disorder. V26, R11's Guardian stated R11 had no history of mental illness. R6 was sitting in his recliner, hair appeared disheveled, was in just shorts, fingernails were long and jagged, and he had facial hair. R6 stated he has been at the facility for approximately a year and has only had 5 showers. R6 had no documented showers given. R43 stated she had not received showers twice weekly as scheduled and felt dirty. R48 stated she had not been showering twice weekly and felt sticky all over from being sweaty and lying in bed. R43 and R48's shower sheets dated December 2025, January 2026 and February 2026 lacked documentation showers were received twice weekly. The facility did not assess, develop and/or implement a care plan, or provide an ongoing program of activities based on residents' assessments and preferences for R51 and R11. The facility did not assess or address R1's change in condition and ensure diagnostic tests were completed as ordered which resulted in hospitalization on 2/25/26. The hospital records documented R1 was lethargic, had a cough, was short of breath, wheezing, confused and tested positive for RSV (Respiratory Syncytial Virus), Acute Bronchiolitis due to RSV, Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) and Acute Hypoxia Respiratory Failure. R1 was ultimately transferred to another hospital for a higher level of care. R1 was still hospitalized upon exit on 3/3/26. R8 had a physician's order to remove an indwelling catheter and implement voiding trial. Staff denied knowledge of a voiding trial or that urinary output should have been monitored and recorded. R55 was observed to have oxygen at 2 liter per nasal cannula. R55's oxygen tubing had not been changed weekly as ordered and the prefilled humidification bottle was empty. R55 stated he had requested it to be refilled for 2 days and now had a dry nose. V1/Administrator stated she did not have documentation demonstrating staff employed at the facility received education and competencies related to the facility's standards, policies, and procedures. R48 was observed resting in bed with the light out. Two medications were in a medicine cup sitting on her bedside table. R48 woke up, turned her light on and took her medications. R48 did not have a physician's order or was it care planned to self-administer medications. The facility did not ensure medications were safely administered. The facility did not dispose of food which was not safe for (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Many	consumption. The facility failed to properly contain garbage and refuse in the facility's dumpsters. The facility failed to ensure residents and staff were monitored and tracked for communicable diseases, ensured a process to prevent the spread of diseases to other residents and staff, wear masks properly while in close proximity to residents, to wear appropriate PPE (Personal Protective Equipment) for Enhanced Barrier Precautions and failed to perform hand hygiene. The facility failed to provide a Pneumococcal Immunization to 2 residents (R1, R60) that requested to receive it and failed to offer a Pneumococcal Immunization to 3 (R13, R52, R55) residents. The facility did not maintain the facility by repairing holes in the wall, torn wallpaper and exposed dry wall. V1/Administrator stated she did not have documentation demonstrating staff employed at the facility received the required staff training/education and competencies for Infection Prevention and Control, Compliance and Ethics. In addition, the is no documentation Certified Nurse Aides were provided and completed a minimum of 12 hours of in-service training per year.

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F 0684 Level of Harm - 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** Based on observation, interview and record review, the facility failed to assess a resident's change in condition and ensure diagnostic tests were completed as ordered for one of two residents (R1) with a change in condition, in a sample of 41. This failure resulted in R1 being transferred to the hospital with a diagnosis of RSV (Respiratory Syncytial Virus), Findings include: The Licensed Practical Nurse (LPN) and Registered Nurse (RN) job descriptions, dated 7/2023, documents to chart nurse's notes in an informative and descriptive manner that reflects the care provided to the residents, as well as the resident's response to the care. The nurse must be knowledgeable of nursing and medical practices and procedures. The Assessment of Resident policy documents to document the resident's comments, complaints as appropriate and assessment findings in the nurse's progress notes and initiate nursing interventions. R1 was admitted on [DATE] with diagnoses of Orthopedic Aftercare, Fracture of Femur Shaft, Morbid Obesity, Chronic Respiratory Failure, Type 2 Diabetes and Major Depressive Disorder. The Minimum Data Set, dated [DATE] section C documents R1 had a Brief Interview for Mental Status score of 15, cognitively intact. The Active Physician Orders on 2/20/26 at 3:10 PM included an order for a chest x-ray. On 2/24/26 at 10:30 AM, R1 stated she did not feel well. Complained that her chest felt heavy and it was hard to breathe. When asked if she had sputum, she said Yes. I've been bringing up (coughing up) yellow and greenish junk. R1 stated she had not had a chest x-ray because They (contracted x-ray staff) never came. On 2/24/26 at 11:00 AM, V3 (Assisting Director of Nursing/Infection Preventionist) was unaware R1's chest x-ray had not been completed. V3 stated the x-ray staff come whenever they have the staff to do the x-ray. V3 stated R1 had not been tested for Influenza, RSV (Respiratory Virus) or COVID-19 because testing is not done unless ordered by the Physician. On 2/25/26 at 9:15 AM, R1 stated she felt even worse than yesterday, appeared to have difficulty breathing and stated No one pays attention to me. I'm going to die. On 2/25/26 at 9:20 AM, V3 (Assisting Director of Nursing/Infection Preventionist) was notified by this surveyor of R1's complaints of her difficulty breathing, comments about staff not paying attention to her and feeling like she was going to die. R1's Progress Note documents on 2/20/26, R1 was weak and had a cough which was productive at times with yellowish/greenish mucus, wheezing throughout lung fields and received a new order for a chest x-ray; on 2/21/26, awaiting chest x-ray, still wheezing; on 2/23/26 and on 2/24/26, still wheezing. The progress notes do not document that vital signs or oxygen saturations were monitored between 2/20/26 and the morning of 2/25/26 (after V3 was notified of R1's complaints by surveyor); on 2/25/26 at 10:00 AM, documents R1 was confused, lethargic, responds to verbal stimuli but falls right back to sleep, shallow respirations, lung sounds diminished with Rhonci (rattling lung sound cause by obstructions or secretions in the large airway), oxygen saturation of 53% (normal limits are 90-100%), oxygen was applied at 2 L (liters) and oxygen saturations went up to 72%, oxygen increased to 4 L and oxygen saturations went up to 76%-78%, V39 (Medical Director) was notified of altered level of consciousness and hypoxia (low oxygen saturation) and received orders to send R1 to hospital. R1 remains hospitalized as of 3/3/36. The Emergency Department Physician Notes dated 2/25/26 documents upon admission, R1 was lethargic, had a cough, was short of breath, wheezing, confused and tested positive for RSV (Respiratory Syncytial Virus), Acute Bronchiolitis due to RSV, Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) and Acute Hypoxia Respiratory Failure and was ultimately transferred to another hospital for a higher level of care.R1's Hospital Inpatient Progress Notes dated 2/25/26, documents R1's Primary Diagnoses are Acute Metabolic Encephalopathy due to Hypercarbia, Acute and Chronic Hypoxemia and Hypercarbic Respiratory Failure, Acute Chronic Obstructive Pulmonary Disease (COPD) Exacerbation secondary to RSV Bronchiolitis and Acute Kidney Injury.On 2/20/26 an Infection Screening Evaluation documents R1 had no active infection, had a new onset of functional decline, new/unchanged lung exam abnormality, new/increased cough, productive/purulent sputum and Loeb's Criteria was (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	triggered as suspected Lower Respiratory Tract Infection and McGreer's Criteria triggered suspected Bronchitis or Tracheobronchitis.On 3/3/26 at 12:00 PM, V39 (Medical Director) stated the facility's county was currently at a very high activity level for RSV and that RSV in the facility's resident population can be fatal.On 2/27/26 at 2:30 PM, V32 (Regional Nurse Consultant) stated the facility initiates an Infection Screening Evaluation if a resident is suspected of having an infection. Loeb's and/or McGreer's Criteria are utilized to determine if there is an infection. V32 reviewed R1's record and stated an Infection Screening Evaluation had been started on 2/20/26 although had not been completed until V32 closed the evaluation during the interview. V32 agreed R1's record did not include documentation that ongoing assessments were conducted, and her condition was monitored after the change in condition was identified nor was an x-ray was completed as ordered and should have been.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on record review and interview, the facility failed to ensure that nursing staff (Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants) were competent to perform their job duties as evidenced by the facility's lack of education, in-service, and competency assessment records. This failure has the potential to affect all 67 residents residing within the facility.Findings include:Findings include:The Facility Resident Census Roster and Facility Matrix/802, dated 2/24/26, were reviewed. The Census Roster documented 67 residents resided in the facility.The facility's Facility Assessment Tool for (facility) 11/1/2025-11/1/2026, dated 12/9/25, documents, Staff training/education and competencies: See Healthcare Academy (online education platform) to include but not limited to: communication; residents' rights and facility responsibilities; abuse, neglect, and exploitation; infection control; culture change; identification of resident changes in condition; and cultural competency. Consider the following competencies (this is not an inclusive list): person-centered care, activities of daily living, disaster planning and procedures, infection control, medication administration, measurements (vital signs), resident assessment and examination, caring for persons with Alzheimer's or another dementia, specialized care (catheterization insertion/care, colostomy care, wound care/dressings, dialysis care, etc.), and caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder. This same document states, Required in-service training for nurse aides. In-service training must: Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year; Include dementia management training and resident abuse prevention training; Address areas of weakness as determined in nurse aides' performance reviews and facility assessment and may address the special needs of residents as determined by facility staff; For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.On 3/3/26 at 11:00 AM, V1/Administrator stated she did not have documentation demonstrating staff employed at the facility received education and competencies related to the facility's standards, policies, and procedures. V1 stated she reviewed the reports for the required education in the online education platform and most of the required in-services/education for staff members were either incomplete or not completed at all. On 3/3/26 at 3:45 PM, V31/Regional Director of Operations confirmed all staff should receive regular training and education to ensure competence. V31 stated there was no documentation to show all staff received their required education and training to ensure competence.

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Arcadia Care Toulon	700 E Main St Toulon, IL 61483

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation interview and record review, the facility failed to monitor stored fresh produce and destroy spoiled produce stored in the kitchen's walk-in refrigerator. This failure has the potential to affect all 67 residents residing in the facility.Findings include:The Facility Resident Census Roster and Facility Matrix/802, dated 2/24/26, were reviewed. The Census Roster documented 67 Residents resided in the Facility. The facility's Food & Supplies: Storage policy dated 01/2026 documents, Food and supply storage areas shall be maintained in a clean, safe and sanitary manner.On 2/24/26 at 8:50am a produce box in the kitchen's walk-in refrigerator containing whole individual zucchini squash included three zucchini squash with wrinkled areas, dark areas approximately 1/2-centimeter square, several open white spots approximately 1 centimeter square, and soft areas noted on each of the three-zucchini squash.On 2/24/26 at 8:50am V14 Dietary Manager verified the three spoiled zucchini squash were moldy and should not be served to the residents and should have been thrown away.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to properly contain garbage and refuse in the facility's dumpsters. This failure has the potential to affect all 67 residents residing in the facility posing the risk of attracting insects, pests and rodents to the facility.Findings include: The Facility Resident Census Roster and Facility Matrix/802, dated 2/24/26, were reviewed. The Census Roster documented 67 Residents resided in the Facility. The facility was unable to provide a waste disposal policy. On 2/26/25 at 11:30 AM, V6 (Maintenance Director) stated the facility disposes of garbage and refuse outside in two large trash dumpsters located behind the facility. The dumpsters should be closed and all garbage stored inside the dumpsters and not on the ground around the dumpsters.On 2/26/26 at approximately 2:45 PM, both dumpsters were uncovered, full and overflowing with garbage bags and refuse. Six large bags of garbage were on the ground around the dumpsters and there is a foul odor emanated from the dumpster storage area.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** These failures resulted in two deficient practices.A. Based on interview, observation and record review, the facility failed to ensure residents and staff were monitored and tracked for communicable diseases and ensure a process to prevent the spread of diseases to other residents and staff. The facility also failed to wear masks properly while in close proximity to residents. These failures have the potential to affect all 67 residents who currently reside in the facility.B. Based on observations, interview and record review, the facility failed to wear appropriate PPE (Personal Protective Equipment) for Enhanced Barrier Precautions and failed to perform hand hygiene for four of twenty-four residents (R2, R5, R27, R60) reviewed for Infection Control, in a sample of forty-one. The facility's Daily Census Report, dated 2/24/26, documents 67 residents reside in the facility. A. Findings Include: 1. On 2/24/26 upon entrance to the facility, there were multiple signs stating, Please wear masks due to high rate of respiratory illnesses in the community. The current Weekly ARI (Acute Respiratory Illness) level for the facility's county for Influenza was marked moderate and RSV (Respiratory Syncytial Virus) was marked very high. On 2/24/26 at 8:50 AM, V4 (Certified Nurse Aide) was seated and feeding R11 and R63. V4 (CNA) was coughing, sneezing and rubbing her nose and face area frequently. V4 sneezed and said, I'm sorry, I have Laryngitis. V4's voice was hoarse when she spoke. On 2/24/26 at 8:30 AM, V14 (Dietary Aide) was in the main dining room with multiple resident's present preparing food and serving residents with her mask under her nose. On 2/24/26 at 8:30 AM, V7 (Activity Aide) was in the main dining room leaning over on tables talking to multiple residents with her mask under her nose. On 2/24/26 at 8:50 AM, V5 (/CNA) was seated and feeding R29 and R51 with her mask under her nose. On 2/24/26 throughout breakfast, V10 (Registered Nurse) had been present in the dining room and confirmed that V14 (Dietary Aide), V7 (Activity Aide), V5 (CNA) all had their masks under their noses while in close proximity to residents. V10 (RN) also confirmed V4 (CNA) had her mask under her nose and had been sneezing, coughing, touching her face and that V4 had a hoarse voice. On 2/25/26 at 8:00 AM, V15 (CNA/Scheduler/Transporter) was serving trays in the main dining room to multiple residents with mask under her nose. V15 was frequently touching her face/mask/nose. On 2/25/26 at 10:20 AM, V20 (Certified Nurse Aide) was in R2's room talking to her, V20 was standing within arm's reach of R2 with her mask under her chin. On 2/25/26 at 1:15 PM, V14 (Dietary Aide) was in main dining room picking up condiments off the tables where multiple residents were sitting with her mask under nose. On 2/26/26 at 8:15 AM, V30 (Licensed Practical Nurse) was passing medications to multiple (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	residents with her mask under her nose. On 2/26/26 at 10:05 AM, V21 (CNA) wa transferring R55 from chair to bed with her mask under nose. V21 stated It falls down and sometimes poke me in the eye when she is giving cares. On 2/26/26 at 1:45 PM, V11 (CNA) was in hallway with multiple residents present with her mask under her nose. On 3/3/26 at 9:00 AM, V3 (ADON/Infection Preventionist) stated the facility was requiring mask for all staff and visitors because corporate says we have to. On 3/3/26 at 12:00 PM, V39 (Medical Director) stated respiratory illnesses, especially RSV are everywhere right now. Everyone should be wearing masks that cover their mouth and nose and wash their hands frequently to control the spread. V39 stated that the elderly in nursing homes usually have multiple comorbidities and can't handle the respiratory viruses that are going around in the community. If (Nursing Home Residents) get sick they could get a lot sicker than people who are healthy, they can get very sick and actually die from it. The Center for Disease Control (CDC) Viral Respiratory Pathogen Toolkit for Nursing Homes dated 1/23/26, documents Preventing the spread of respiratory viruses in nursing homes requires a comprehensive approach that includes not only vaccination, but also testing, treatment, and the prompt implementation of proven infection prevention and control measures. Examples of Respiratory Pathogens are COVID, Influenza (flu) and RSV (respiratory virus). Be aware when levels of^respiratory virus spread^are increasing in the community. Develop plans to provide rapid clinical evaluation and intervention to ensure residents receive timely antiviral treatment and/or prophylaxis when indicated. When an infection due to a respiratory virus is suspected in a resident or HCP (Healthcare Provider), it is important to take rapid action to prevent the spread to others in the facility. When an infection due to a respiratory virus is suspected in a resident or HCP, it is important to take rapid action to prevent the spread to others in the facility. Apply appropriate Transmission-Based Precautions for symptomatic residents based on the suspected cause of their infection. Test residents and Health Care Providers with new respiratory illness signs or symptoms. At a minimum, testing should include SARS-CoV-2 and influenza viruses with consideration for other causes (e.g., RSV). Upon entrance to the facility on 2/24/26, 2/25/26 and 2/26/26, the facility's front door had a sign posted which documented the county's acute respiratory illness rate was at high risk and to wear a mask while in facility. 2. R1 was admitted on [DATE] with diagnoses of Orthopedic Aftercare, Fracture of Femur Shaft, Morbid Obesity, Chronic Respiratory Failure, Type 2 Diabetes and Major Depressive Disorder. The Minimum Data Set, dated [DATE] section C documents R1 had a Brief Interview for Mental Status score of 15, cognitively intact. On 2/24/26 at 10:30 AM, R1 was observed in the dining room at a table with four other residents all without a mask and stated she did not feel well. Complained that her chest felt heavy and it was hard to breathe. When asked if she had sputum, she said Yes. I've been bringing up (coughing up) yellow and greenish junk. R1 stated she had not had a chest x-ray because They (contracted x-ray staff) never came. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/24/26 and 2/26/26, R1's room did not indicate using Transmission Based Precautions nor was personal protective equipment available for staff use. On 2/25/26 at 9:15 AM, R1 was observed in the Television seating area with six other residents all without a mask and stated she felt even worse than yesterday, appeared to have difficulty breathing and stated No one pays attention to me. I'm going to die. An Infection Screening Evaluation dated 2/20/26 (created date 2/25/26 and locked date of 2/27/26) documents R1 was experiencing new onset of functional decline, new or changed lung exam abnormalities, new or increased cough and productive-purulent sputum. Loebs Criteria: Suspected Lower Respiratory Tract Infection. McGeer's Criteria: Suspected Bronchitis or Tracheobronchitis. R1's Progress Note documents on 2/20/26, R1 was weak and had a cough which was productive at times with yellowish/greenish mucus, wheezing throughout lung fields and received a new order for a chest x-ray; on 2/21/26, awaiting chest x-ray, still wheezing; on 2/23/26 and on 2/24/26, still wheezing. The progress notes do not document that vital signs or oxygen saturations were monitored between 2/20/26 and the morning of 2/25/26 (after V3 was notified of R1's complaints by surveyor); on 2/25/26 at 10:00 AM documents R1 was confused, lethargic, responds to verbal stimuli but falls right back to sleep, shallow respirations, lung sounds diminished with Rhonci (rattling lung sound cause by obstructions or secretions in the large airway), oxygen saturation of 53% (normal limits are 90-100%), oxygen was applied at 2 L (liters) and oxygen saturations went up to 72%, oxygen increased to 4 L and oxygen saturations went up to 76%-78%, V39 (Medical Director) was notified of altered level of consciousness and hypoxia (low oxygen saturation) and received orders to send R1 to hospital. R1 remains hospitalized as of 3/3/26. The Emergency Department Physician Notes dated 2/25/26 documents upon admission, R1 was lethargic, had a cough, was short of breath, wheezing, confused and tested positive for RSV (Respiratory Syncytial Virus), Acute Bronchiolitis due to RSV, Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) and Acute Hypoxia Respiratory Failure. And was ultimately transferred to another hospital for a higher level of care. The Call Off Symptom Tracking-Employees log dated February 2026, documents five employees called off due to cough and runny nose: one on 2/3/26 was tested on [DATE] (2 days after) and was positive for RSV and was treated with antibiotics; one on 2/10/26 tested positive for influenza; two on 2/20/26 had symptoms of cough and a runny nose although were not tested and returned to work on 2/14/26. On 2/24/26 at 11:00 AM, V3 (Assisting Director of Nursing/Infection Preventionist) was unaware R1's chest x-ray had not been completed. V3 stated R1 had not been tested for Influenza, RSV (Respiratory Virus) or COVID-19 (all which are communicable/contagious diseases) because respiratory pathogen testing is not conducted unless ordered by the Physician. A symptomatic staff member could have respiratory pathogen testing done by their own provider if they choose to do so. On 2/27/26 at 10:40 AM, V3 (Assisting Director of Nursing/Infection Preventionist) and V32 (Regional Nurse Consultant) stated the facility does not have a policy on testing for communicable diseases. V3 stated they would only test if a physician ordered it. V32 stated they would do a Mcgreer's screening and/or Loeb's Screening. V3 reviewed R1's record and stated an Infection Screen Evaluation was conducted on 2/20/26 but had not been completed or finalized in the electronic health record. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/3/26 at 12:00 PM, V39 (Medical Director) stated the facility's county was currently at a very high activity level for RSV and that RSV in the facility's resident population can be fatal. B. Findings Include: The Facility's Enhanced Barrier Precautions policy dated 12/2025 documents Enhanced Barrier Precautions (EBP): recommendations now include use of residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. Standard Precautions must be followed with all cares. Additionally, gown and gloves must be worn when providing the following cares: Dressing, Bathing/Showering, Providing Hygiene, Changing Linens, Incontinence Care, Medical Device Care, and Wound Care. 1. R2's Medical Record documents Enhanced Barrier Precautions for (indwelling catheter) and chronic wounds. Throughout the survey, R2's door had a sign hanging that said, Enhanced Barrier Precautions. On 2/25/26 at 1:30 PM, V24 (Licensed Practical Nurse) performed indwelling catheter care and then wound care using only Standard Precautions. V24 did not don a gown. On 3/3/26 at 9:00 AM, V24 (LPN) confirmed that she had not worn a gown while performing catheter care and wound care for R2. Oh, right. That (Enhanced Barrier Precautions) new thing. I should have worn a gown. The Centers for Disease Control and Prevention February 27, 2024 publications titled Clinical Safety: Hand Hygiene for Healthcare Workers documents glove usage is not a substitute for hand hygiene and hand hygiene should be performed immediately after glove removal. 2. R5's medical record documents R5 was admitted to the facility on [DATE] with diagnoses to include Spina Bifida, Paraplegia, Chronic Obstructive Pulmonary Disorder, Hydronephrosis, ESBL (Extended-Spectrum Beta-Lactamase) Infection, and Urinary Retention. R5's Physician's Order dated 11/03/2025 documents Straight catheterization four times daily. On 02/25/2026 at 2:15 PM, R5 was lying in bed. V18 (LPN) went to right side of the bed and opened a sterile intermittent urinary catheterization kit with nonsterile gloves on. V18 removed a wrapped package of sterile gloves from the kit and placed on the bed. V18 removed sterile drape, opened the drape, and then placed it on the bed. V18 continued to wear nonsterile gloves. V18 removed the cleansing swabs from catheterization kit, opened them, and placed them on the sterile drape. V18 opened lubricant packet and squeezed lubricant onto sterile drape. V18 then used cleansing swabs to cleanse R5's urethral meatus and placed the soiled cleansing swabs back onto the sterile drape. V18 removed nonsterile gloves and donned sterile gloves. Hand hygiene was not performed prior to applying sterile gloves. V18 then removed the sterile single use catheter from the packaging, dipped tip of catheter into the lubricant on the sterile field and inserted the catheter into the urinary meatus. 3. R27's medical record documents R27 was admitted to the facility on [DATE] with diagnoses to include Paraplegia, Hypothyroidism, Coarctation of Aorta, Viral Hepatitis C, History of Methicillin Resistant Staphylococcus Aureus Infection, and Arthritis. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R27's Physician's Order dated 01/12/2026, documents Right lower extremity: cleanse with normal saline, pat dry, apply Dakins (antiseptic solution) soaked gauze then apply hydrocolloid paste to peri wound (skin and tissue immediately surrounding a wound) only. Cover with border dressing. On 2/25/26 at 2:30 PM, R27 was sitting in his room in his motorized chair with previous dressing already removed from wound on right outer knee. V18 (LPN) donned gown and gloves to perform R27's wound care. V18 cleansed wound and placed hydrocolloid paste around wound. V18 then changed gloves without performing hand hygiene in between glove change. V18 packed wound with Dakins soaked gauze and covered the wound with a bordered foam dressing. 4. R60's Minimum Data Set (MDS) Assessment, dated 9/8/2025, documents R60 was admitted to the facility on [DATE]. R60's Care Plan, dated 12/11/25, documents, R60 has medical diagnoses including but not limited to: Osteomyelitis Chronic Obstructive Pulmonary Disease, Psoriasis, Personal History of Other Diseases of the Circulatory System, and Chronic Pain. This same care plan documents, R60 has an Actual skin impairment: Non-pressure wound to the left lower leg, distal from the knee as a focus. There is no documented intervention for Enhanced Barrier Precautions (EBP) under R60's focus of Actual skin impairment, nor does this same care plan include a specific focus for EBP with a goal(s) and interventions. R60's Physician Order Summary, dated 2/27/26, documents a telephone Treatment Administration Record order was received from V39/Medical Director for Enhanced Barrier Precautions every shift and was created on 2/24/26 at 9:33 AM by V3/Assistant Director of Nursing with an order effective date of 2/17/26 at 9:33 AM. On 2/24/2026 at 9:09 AM, no EBP sign was observed on or near R60's door. At this same date and time, there was no Personal Protective Equipment (PPE) observed in or near R60's room, or on the hall that R60 resides. On 2/24/2026 at 11:35 AM, R60 stated he has a wound below his left knee. R60 stated the EBP sign was not on R60's door previously. Staff just came and put that sign (EBP sign) up on my room door before you came in to talk to me. No one wears a gown when taking care of my wound. On 2/27/26 at 3:32 PM, V3/Assistant Director of Nursing stated R60 has a vascular wound that started in December of 2025. V3 stated (R60) should be in EBP due to a vascular wound on (R60's) left leg, staff should wear PPE while providing high contact cares to R60, and PPE should be easily accessible to staff outside of R60's room since (R60) requires EBP due to his wound. V3 verified the telephone order for EBP was entered on 2/24/26 at 9:33 AM by V3 and was backdated to 2/17/26 at 9:33 AM. On 2/27/26 at 3:35 PM, V18/Licensed Practical Nurse verified no PPE was in or by R60's room, or on the hall where resident resides. V18 stated PPE should be readily available to staff since R60 is on EBP for the wound to his left leg.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to maintain or repair residents' missing and peeling wall coverings and exposed dry wall for 8 residents (R13, R16, R31, R39, R42, R44, R62, R69), and failed to repair the wall area between the HVAC/heating, ventilation, air-conditioning unit and the window sill for two residents (R30, R37) in the total sample of 41 residents reviewed for clean, comfortable and homelike environments. This failure has to potential to affect all 67 residents living in the facility Findings include: The facility room roster, dated 2/24/26, documents 67 residents reside in the facility.The facility's Maintenance Director Job Description, dated 03/2024, documents The primary purpose of the Maintenance director is to plan, organize, develop, and direct the overall operation of the Maintenance in accordance with current federal, state and local standards, guidelines, and regulations governing our facility., and Essential Duties and Responsibilities: Repair facility/resident property as necessary. In the event of inability to repair, coordinate with outside vendors to make repair or replace as cost effectively as possible. On 2/24/26 at 1:45 PM, the room repair needs for the following residents' rooms were identified: In R42 and R69's room a section of wallpaper approximately two feet by six inches was peeling and drywall was exposed on the wall across from R42's bed; R39 and R62's room a six inch wide by 1-1/2 inch high hole through the drywall was present behind the room door, where the door handle hits the wall; R13 and R44's room, a 1-1/2 feet by 8 inch area of peeling wallpaper and exposed drywall on the wall next to the ?A' bed in the room; R16's room had a four feet long by 2 1/2 foot wide area of exposed dry wall with peeling wallpaper. The following areas were identified in R30 and R37's room, between the HVAC unit under the window and the window sill: several black spots in the caulking, identified as mildew by V6/Maintenance Director, crumbling and missing caulking, broken wooden framing, and a hole through the drywall measuring approximately 3-inches by 2 1/2-inches, exposing wire mesh. On 2/25/26 at 1:50 AM, a tour of the facility was conducted by this surveyor with V6 Maintenance Director who stated the rooms identified in need of repairs had yet been addressed in the remodel attempt of the facility. Regarding the rooms in need of repairs, V6 stated the following: We have an app called 'Tels' that they use to notify me of work requests in the building. My computer has been down for a while, and I didn't get work requests. On 2/27/26 at approximately 9:50 AM, V6 provided a computer-generated compilation of work orders dated 6/30/25 through 1/24/26. This compilation of work orders included 11 work orders requesting repairs on the designated hall where R13, R16, R30, R31, R37, R39, R42, R44, R62, and R69's rooms are located. The February 2026 work order/repairs request list was not provided as of 3/3/26.On 2/27/26 at approximately 1:00 PM, V31 (Regional Director of Operations) verified the areas in need of repair in the rooms identified above.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on record review and interview, the facility failed to ensure all staff received mandatory training and education for infection prevention and control. This failure has the potential to affect all 67 residents residing within the facility.Findings include:The Facility Resident Census Roster and Facility Matrix/802, dated 2/24/26, were reviewed. The Census Roster documented 67 residents resided in the facility.The facility's Facility Assessment Tool for (facility) 11/1/2025-11/1/2026, dated 12/9/25, documents, Staff training/education and competencies: see Healthcare Academy (online education platform). Infection control - a facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program.On 3/3/26 at 11:00 AM, V1/Administrator stated she did not have documentation demonstrating staff employed at the facility received the required staff training/education and competencies. V1 stated she reviewed the reports for the required education in the online education platform and most of the required in-services/education for staff members were either incomplete or not completed at all. On 3/3/26 at 3:45 PM, V31/Regional Director of Operations confirmed all staff should receive regular training and education to ensure competence. V31 stated there was no documentation to show all staff received their required education and training to ensure competence.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide training in compliance and ethics. Based on record review and interview the facility failed to ensure all staff were provided education, in-services, and training regarding the facility's standards, policies, and procedures for Compliance and Ethics. This failure has the potential to affect all 67 residents residing within the facility.Findings include:The Facility Resident Census Roster and Facility Matrix/802, dated 2/24/26, were reviewed. The Census Roster documented 67 residents resided in the facility.The facility's Facility Assessment Tool for (facility) 11/1/2025-11/1/2026, dated 12/9/25, documents, Staff training/education and competencies: See Healthcare Academy (online education platform) to include but not limited to: communication; residents' rights and facility responsibilities; abuse, neglect, and exploitation; infection control; culture change; identification of resident changes in condition; and cultural competency. Consider the following competencies (this is not an inclusive list): person-centered care, activities of daily living, disaster planning and procedures, infection control, medication administration, measurements (vital signs), resident assessment and examination, caring for persons with Alzheimer's or another dementia, specialized care (catheterization insertion/care, colostomy care, wound care/dressings, dialysis care, etc.), and caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder. This same document states, Required in-service training for nurse aides. In-service training must: Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year; Include dementia management training and resident abuse prevention training; Address areas of weakness as determined in nurse aides' performance reviews and facility assessment and may address the special needs of residents as determined by facility staff; For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.On 3/3/26 at 11:00 AM, V1/Administrator stated she did not have documentation demonstrating staff employed at the facility received education and competencies related to Compliance and Ethics. V1 stated she reviewed the reports for the required education in the online education platform and most of the required in-services/education for staff members were either incomplete or not completed at all. On 3/3/26 at 3:45 PM, V31/Regional Director of Operations confirmed all staff should receive regular training and education to ensure competence. V31 stated there was no documentation to show all staff received their required education and training to ensure competence.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure Certified Nursing Assistants (CNAs) were provided and completed a minimum of 12 hours of inservice training per year. This failure has the potential to affect all 67 residents residing in the facility. Findings include:The Facility Resident Census Roster and Facility Matrix/802, dated 2/24/26, were reviewed. The Census Roster documented 67 residents resided in the facility.The facility's Facility Assessment Tool for (facility) 11/1/2025-11/1/2026, dated 12/9/25, documents, Required in-service training for nurse aides. In-service training must: Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year; Include dementia management training and resident abuse prevention training; Address areas of weakness as determined in nurse aides' performance reviews and facility assessment and may address the special needs of residents as determined by facility staff; For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.On 3/3/26 at 11:00 AM, V1/Administrator stated she did not have documentation demonstrating the CNAs working at the facility received the minimum of 12 hours of required education. V1 stated she reviewed the reports for the required education in the online education platform and most of the required in-services were either incomplete or not completed at all. On 3/3/26 at 3:45 PM, V31/Regional Director of Operations confirmed the CNAs working at the facility should receive 12 hours of continuing education yearly at minimum. V31 stated there was no documentation to show all CNAs received 12 hours of the minimum yearly training.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide a Pneumococcal Immunization to two residents (R1, R60) that requested to receive it and failed to offer a Pneumococcal Immunization to three (R13, R52, R55) residents out of 8 residents reviewed for immunizations, in a sample of 41.Findings include: The facility's Influenza and Pneumococcal Immunizations Policy dated 12/2025 documents: Each resident is offered a pneumococcal immunization. The resident's medical record includes documentation that indicates, at a minimum, the following: That the resident either received or did not receive the pneumococcal immunization due to medical contraindications or refusal. On 2/25/2026 at 1:00 PM, V3 (ADON/Infection Preventionist) reported a pneumococcal immunization clinic was held at the facility on 12/01/2025. 1. R1's medical record documents R1 was admitted to the facility 09/12/2025 with diagnoses to include Chronic Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease, Diabetes, Depression, and Pneumonia. R1's Physician's Order dated 09/12/2025 documents May have pneumonia vaccine unless contraindicated. R1's Authorization and Release for Vaccinations included in her admission packet (includes but not limited to consents, bed hold policy, resident rights, transfer policies, arbitration agreement, and services provided by facility) indicates R1 requested to receive the pneumococcal vaccine. R1's medical record documents she received an Influenza vaccine on 10/28/2025. R1's medical record did not have a documented pneumococcal immunization.2. R60's medical record documents R60 was admitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease, Depression, Atrial Fibrillation, and Bipolar Disorder.R60's Physician's Order dated 08/26/2025, documents May have pneumonia vaccine unless contraindicated.R60's Authorization and Release for Vaccinations included in his admission packet indicates R60 requested to receive the pneumococcal vaccine.R60's medical record documents R60 received the influenza vaccine on 10/28/2025 and a Covid vaccine on 12/01/2025. R60's medical record did not have a documented pneumococcal immunization.On 02/27/2026 R60 reports he has not received a pneumococcal vaccine, and he wants to have one.3. R13's medical record documents R13 was admitted to the facility on [DATE] with diagnoses to include Dementia, Depression, and Hypertension.R13's Physician's Order dated 11/01/2025, documents May have pneumonia vaccine unless contraindicated.4. R52's medical record documents R52 was admitted to the facility on [DATE] with diagnoses to include Subdural Hemorrhage, Depression, Epilepsy, and Polyneuropathy.R52's Physician's Order dated 11/01/2025, documents May have pneumonia vaccine unless contraindicated.5. R55's medical record documents R55 was admitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease, Diabetes, Venous Insufficiency, Polyneuropathy, and Schizophrenia.R55's Physician's Order dated 11/26/2025, documents May have pneumonia vaccine unless contraindicated.R13, R52 and R55's medical records did not have a Pneumococcal Immunization documented.On 03/03/2026 at 10:15 AM, V1 (Administrator) reported the facility could not find or provide the admission packets including Authorization and Release for Vaccinations forms for R13, R52 and R55.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to treat three residents (R5, R27,R76) with dignity in three reviewed for dignity in a total sample of 41.1. R5's medical record documents R5 was admitted to the facility on [DATE] with diagnoses to include Spina Bifida, Paraplegia, Chronic Obstructive Pulmonary Disorder, Hydronephrosis, and Urinary Retention. On 2/25/26 at 2:15 PM, V11 (Certified Nurse Aide/CNA) and V16 (CNA) transferred R5 via mechanical lift from his wheelchair to his bed. R5's privacy curtain was not pulled prior to V11 and V16 pulling down his pants and incontinent brief to prepare him for catheter procedure. V18 (Licensed Practical Nurse/LPN) entered room and pulled the privacy curtain between R5 and his roommate. 2. R27's medical record documents R27 was admitted to the facility on [DATE] with diagnoses to include Paraplegia, Hypothyroidism, Coarctation of Aorta, Viral Hepatitis C and Arthritis. On 2/25/26 at 2:30 PM, R27 was in his room with the door open. V18 (LPN) placed the treatment cart in front of the doorway. The treatment cart did not cover the width of the doorway. V18 proceeded to provide wound care to R27's right knee wound. 3. R76's Medical Record documents she was admitted on [DATE] with diagnosis to include but not limited to Unspecified Dementia, Severe Depression and Unspecified Intellectual Disabilities. Throughout the survey, R76 seemed confused and did not answer any questions appropriately. On 02/25/2026 at 1:21 PM, V29 (Certified Nurse Aide/CNA) was standing and feeding R76 at lunch. V29 (CNA) was repeatedly referring to R76 as honey and sweetie. On 2/25/26 at 1:30 PM, V29 (CNA) stated she sometimes stands when she assists residents with their meals. V29 stated Oh no, sorry. I shouldn't have said that when asked about referring to R76 with pet names. On 2/25/26 at 1:35 PM, V24 (Licensed Practical Nurse/LPN) stated All staff should sit when they are feeding residents. No one should refer to any residents as honey or anything other than their given name unless the resident requests that. V24 (LPN) confirmed that R76 just admitted to the facility on [DATE] and stated, She is pretty confused and does not answer questions.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview and record review, the facility failed to ensure a resident's toileting preferences and needs were reasonably accommodated for one of one resident (R51) reviewed for accommodation of needs in a sample of 41. Findings include:The facility's Facility Assessment Tool for (facility) 11/1/2025-11/1/2026, dated 12/9/2025, documents under Part 3: Services and Care Based on Residents Needs, Find out what resident's preferences and routines are; incorporate this information into the care planning process. Make sure staff caring for the resident have this information. Record and discuss treatment and care preferences.R51's MDS (Minimum Data Set) assessment, dated 2/10/2026, documents in Section A an admission date of 4/17/2015; Section I documents R51 has Alzheimer's Disease, Non-Alzheimer's Dementia, and Parkinson's Disease; Section GG documents R51 is dependent on staff for transfers and all Activities of Daily Living (ADLs); and Section C documents R51 is rarely/never understood and no Brief Interview for Mental Status (BIMS) completed due to inability to answer BIMS questions.R51's Care Plan, dated 2/19/2026, documents (R51) has an ADL self-care performance deficit r/t (related to) Dementia, limited mobility, (and) limited ROM (Range of Motion) with interventions of: Toilet Use: (R51) is dependent on staff for toileting, Transfer: (R51) is dependent on staff with mechanical lift for transfers between surfaces, discuss with (R51) and (R51's) family/Power of Attorney/POA any concerns related to loss of independence, decline in function, and encourage the resident to participate to the fullest extent possible with each interaction; R51 has impaired cognitive function/dementia or impaired thought processes r/t Alzheimer's, Dementia, Psychotropic drug use with an intervention to communicate with resident/family/caregivers regarding resident's capabilities and needs; (R51) has a history of constipation r/t pain, poor fiber intake, and poor fluid intake; and (R51) has Parkinson's affecting ADLs with an intervention to monitor voiding pattern and continence and implement a toileting program, if needed.On 02/24/26 at 11:09 AM, V57, who is R51's designated responsible party, stated (V57) visits R51 daily and is very involved in R51's care, expressing R51's wishes since she cannot. R51 has difficulty having a bowel movement while lying down and has a history of issues with constipation. She appears uncomfortable when she is laying down and attempting to have a bowel movement. V57 stated staff are aware of R51's toileting preferences as they have had discussions about (R51's) preferences before. Staff tell V57 that R51 cannot be toileted regularly since she needs a mechanical lift to transfer, although staff transfer her to the shower chair on her shower days and she always has a bowel movement as soon as they have her sitting up in the shower chair. V57 states, Sitting up is a natural position for (R51) to have a bowel movement and it is easier for (R51). (R51) would not have constipation issues as much if she was toileted regularly.On 2/25/2026 at 1:58 PM, V29/Certified Nursing Assistant stated R51 is incontinent so we check and change her. We (staff) do not put her on the toilet because she is incontinent.On 2/25/26 at 2:15 PM, two Certified Nursing Assistants (V29 and V8) were observed to get ready to transfer R51 to the bed from her wheelchair. V29 stated R51 was being transferred to the bed for incontinent care.On 2/25/2026 2:40 PM, V16 (Certified Nursing Assistant/CNA) stated we have mechanical lift slings available that are designed for transferring residents requiring a mechanical lift to a toilet or commode. Facility staff are aware of V57's requests for R51 to be toileted. V57 has made several requests to the staff for R51 to be toileted regularly. Facility staff do not transfer R51 to the toilet or commode currently.On 2/24/2026 2:42 PM, V3 (Assistant Director of Nursing) stated she was aware of V57's request for R51 to be transferred to the toilet on a regular basis to attempt to have a bowel movement. Staff can transfer a resident with a mechanical lift and the appropriate sling to a commode for toileting, if desired. The appropriate mechanical lift slings are available in our facility. Staff do not currently transfer R51 to the toilet or commode, but R51 is transferred to a shower chair for showers on scheduled shower days. V3 stated Do you know how long it would take for (R51) to be able to use a commode? (R51) is not transferred to the commode for toileting as it would take a long time. Staff (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would have to transfer (R51) with a Hoyer (mechanical lift) from her wheelchair to her bed to undress her, then transfer her from the bed to the commode, and then, once she is done on the commode, transfer her back to the bed to be dressed again, and lastly, back to the wheelchair from her bed.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to ensure a safe, clean, and comfortable environment for four of 24 residents (R1, R48, R58, R60) reviewed for a homelike environment in a sample of 41. These failures have the potential to affect all 67 residents residing within the facility.Findings include:The facility's Housekeeper Job Description Summary documents the primary purpose of the Housekeeper is to perform day-to-day activities of the Housekeeping Department in accordance with current federal, state, and local standards, guidelines and regulations governing our facility, and as may be directed by the Administrator, and/or the Director of Environmental Services, to assure that our facility is maintained in a clean, safe, and comfortable manner. The essential duties and responsibilities include but are not limited to ensuring work/cleaning schedules are followed as closely as practical and cleaning floors including, sweeping, dusting, damp/wet mopping, stripping, waxing, buffing, disinfecting, etc. The facility's Maintenance Director Job Description Summary documents the primary purpose of the Maintenance Director is to plan, organize, develop, and direct the overall operation of the Maintenance Department in accordance with current federal, state, and local standards, guidelines, and regulation governing our facility, and as may be directed by the Administrator, to assure that our facility is maintained in a safe and comfortable manner. The essential duties and responsibilities include but are not limited to: planning, developing, organizing, implementing, evaluating, and directing the Maintenance Department, its programs and activities, repairing facility/resident property as necessary, ensuring supplies, equipment, etc. are maintained to provide a safe and comfortable environment, and making periodic rounds to check equipment and to assure that necessary equipment is available and working properly. 1. On 2/24/26 at 9:09 AM, leaves were observed scattered in piles on the floor extending from the door at the back of D Hall to the middle of D Hall where R60 resides. On 2/24/2026 at 9:38 AM, R60 stated the leaves are always in the hallway and the hallway floors are frequently dirty. I think they should clean more frequently especially when the leaves blow in the back door. On 2/24/2026 at 9:40 AM, V7/Activities Assistant stated leaves are always on the floor there referring to the area on D Hall by the door. The leaves blow in the door when the door is opened to let residents in and out to smoke. Housekeeping is responsible for cleaning the leaves up, but the floors do not get swept or cleaned like they should. On 2/24/2026 at 11:30 AM, leaves were observed scattered on the floor in the back of D Hall by the exit where they previously were. On 2/24/2026 at 2:45 PM: Leaves were observed in the same area on the floor in the back of D Hall by the exit. On 3/3/26 at 11:50 AM, V6/Maintenance Director stated housekeeping is responsible for cleaning common areas on a daily basis, including the hallways. A deep clean of each hallway is performed on the 22nd of each month. The leaves should have been cleaned up when they were noticed by staff. The facility's Deep Clean Schedule documents halls should be thoroughly cleaned on the 22nd of the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	month. 2. On 2/25/2026 at 1:17 PM, R58 stated his room was cold and he wished his room was warmer. My heater does not work in my room, and it has not been working for a while. I have told the staff before about it and it is still not working. They tell me maintenance will get it fixed. R58's wall heating unit was observed not functioning and R58 was wearing a heavy winter coat in his room at this same date and time. On 2/26/2026 at 10:00 AM, V22/Certified Nursing Assistant stated she was not aware that R58's wall heating unit was not working. On this same date and time, V22 attempted to turn on R58's wall heating unit and the heater turned on but only blew out cold air. V22 stated R58's heating unit was not blowing out any warm air and the room was chilly. V22 stated she would let V6/Maintenance Director know and put in a maintenance ticket for it to be fixed. On 2/26/2026 at 2:30 PM, V6/Maintenance Director verified the wall heating unit was not functioning in R58's room and was not blowing out any warm air. V6 stated he was not aware of any maintenance requests being submitted for R58's wall heating. V6 stated R58 frequently complains of being cold and had a portable heater when he was in a different room on a different hall as he stated it was not warm enough in his room then, too. V6 stated If a heating unit stops working, it is replaced with a new unit. The unit is worked on outside of the resident's room and then the new one is installed. The unit in R58's room needs to be replaced as it is not heating up R58's room. A review of the facility's maintenance work orders was conducted on 2/26/26. There were no documented maintenance work orders for the wall heating unit in R58's room. V6/Maintenance Director verified he did not have a work order for R58's wall heating unit. 3. The Resident Council Meeting Minutes documents on 12/3/25 documents sink is still plugged up in (R1's bathroom) and on 2/4/26 (R1's) bathroom sink still clogging up. On 2/24/26 at 9:45 AM, R48 stated her bathroom sink had been clogged and not available for use since May 2025. She stated the roof had leaked last year and there were brown water stains on the ceilings throughout the building. On 2/24/26 at 11:30 AM, R1 stated her bathroom sink had been clogged for at least six months or more. R1 stated she could not use the sink to brush her teeth or wash her hands after toileting. On 2/24/26 at 9:50 AM, R1 and R48's shared sink was observed to be standing in water approximately half full. On 2/24/26 at 11:15 AM, the C hall (Secured Dementia Care unit) was observed to have two floor drainage caps which were not secured and/or fixed to the floor; one had a screw sticking upward approximately one inch; both which posed a tripping hazard; the nurse's station and television seating area for halls A, B, C and D, the Secured Dementia Care Unit (hall E) dining room had multiple ceiling tiles with brownish discoloration and dust-like material on ceiling vents and surrounding ceiling areas. On 2/25/26 at 10:35 AM, V6 (Maintenance) stated The sink between (R1 and R48) clogs up. I have unclogged it, but it clogs right back up. I'll have to go look at it again. I didn't know they were still having problems with it. V6 stated there is a computerized system for staff to submit workers although V6 has not had access to his computer due to a water leak in the building flooding his office. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V6 stated last year the roof leaked although it had been replaced. The ceiling tile had not been replaced since the roof had been replaced. While the non-secured floor drainage caps were being pointed out to V6, a resident was assisted with walking down the hall with a staff member and shuffling her feet (not picking them up off the floor). V6 stated the resident could have easily tripped or stubbed her toe on the screw that was sticking out of the drain.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure 1 of 1 resident (R9) reviewed for physical restraints was free from physical restraint, in a sample of 41. Findings include:The facility's Restraint Policy dated 12/2025 documents the definition of a physical restraint includes self release belts if the resident is physically incapable of releasing the belt.The facility's Restraint Policy dated 12/2025 documents:Guidelines:Residents that are admitted with a Physician's order for restraint use shall have a restraint use assessment performed and a physician order obtained for the release of restraints with supervision during the assessment process, as appropriate, or an order to discontinue use.Periodic assessments shall address the resident's status in an effort to reduce or eliminate restraints whenever possible and assure the restrictive method is used which allows the resident to function at their highest practicable level.The use of restraints will be reviewed by the Interdisciplinary Team periodically and at least quarterly thereafter.Restraint assessments are performed at a minimum with the initial application, change in type of restraint and change in the resident's condition which affects how the resident responds to current treatment.R9's medical record documents R9 was admitted to the facility on [DATE] with diagnoses to include Hereditary Spastic Paraplegia and Lack of Coordination.R9's Physician's Order dated 08/23/2023, documents May use lap positioning device on chair while up to enhance positioning because of poor trunk control related to spastic paraplegia. Release and reposition resident every two hours while device is in place, remove during meals every shift.R9's Care Plan Intervention dated 06/27/2024, documents Enabler in use, self-releasing belt while in motorized wheelchair.R9's Care Plan Intervention dated 10/25/2023, documents Quarterly and as needed assessment of needs/functional ability and progress note for restraint need/restraint reduction.R9's Health Status Progress Note dated 02/16/2026 at 3:48 PM, documents R9 is alert and oriented.On 02/25/26 at 10:54 AM, R9 was observed sitting in motorized wheelchair in the hallway near her room. R9 has seat belt fastened. R9 was unable to release seat belt when prompted.On 02/27/26 at 8:00 AM, R9 was in Physical Therapy. When R9 was asked if she could unfasten her seat belt, she stated No. V51 (Physical Therapy Aide) was present and confirmed R9 said that she cannot unfasten her seat belt.R9's Electronic Health Record did not contain a Restraint Assessment since 2024.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to have appropriate indications for use for psychotropic medications for three of five residents (R6, R7, R11) reviewed for unnecessary medications in a sample of forty-one.Findings include: The Facility's Gradual Dose Reduction policy dated 2/2018, documents the purpose of the policy is to ensure that residents are not given psychotropic drugs unless psychotropic drug therapy is necessary to treat a specific or suspected condition as per current standards of practice, and are prescribed at lowest therapeutic dose to treat such conditions. R6's Medical Record documents she was admitted to the facility on [DATE] with diagnosis to include but not limited to Metabolic Encephalopathy, Severe Dementia and Unspecified Mood Disorder. R6's Physician Order Sheet dated February 2026 documents, R6 receives Depakote Sprinkles (medication approved for use of Bipolar Mania) 250 mg (milligrams) twice a day for Dementia with Anxiety and Seroquel (Anti-psychotic Medication) 25 mg twice daily for Dementia.R6's behavior monitoring for the past three months does not document any harmful behaviors for the resident herself or other residents. On 2/24/26 at 11:00 AM V24 (Licensed Practical Nurse) stated R6 gets very anxious and tries to stand up all the time. V24 denied R6 ever hitting staff or other residents. Throughout the survey R6 was in her padded reclining wheelchair. R6 was noted to be talking to herself frequently. When spoken to, she stopped talking and smiled at speaker then resumed talking to herself. R7's Medical Record documents she was admitted [DATE] with diagnosis to include but not limited to Dementia, Depression and Chronic Obstructive Pulmonary Disease. R7's PASRR (Pre admission Screening Resident Review) dated 10/1/2024, documents A PASRR Level II evaluation is not required at this time for the following reason: Information supports that the neurocognitive disorder is progressed and primary over the co-occurring mental health condition. R7's Physician Order Sheet dated February 2026, documents R7 takes Lithium (Mood Stabilizing Medication) 300 mg daily for Depression, Mirtazapine (Antidepressant) 30 mg daily for depression, Trazadone (Antidepressant) 100 mg every night for insomnia and Velafaxine (Antidepressant) 150 mg daily for depression. R7's Psychotropic Medication Consents dated 3/7/26 documents that R7 takes all of the psychotropic medications listed for Depression. On 2/24/26 at 3:00 PM, V2 (Director of Nursing) stated I have no idea why she is on so many medications for Depression. You need to ask (the Psychiatrist). R7's Behavior Monitoring and Interventions report from 12/01/25 to present, documents No behavior observed throughout. Throughout the survey, R7 was alert and oriented and denied any concerns. R7 stated she wasn't sure what medications she was on. R7 visited with her peers and seemed to be very engaged with initiating games to play with peers.On 2/24/26 at 11:00 AM, V24 (Licensed Practical Nurse) stated R7 is very social and friendly. V24 (LPN) denied witnessing or hearing of any behavioral issues with R7. R11's Medical Record documents that she was admitted to the facility on [DATE] with diagnosis to include but not limited to Alzheimer's, Paranoid Personality and Hypertension. R11's Physician Order Sheet dated February 2026, documents R11 takes Mirtazepine (Antidepressant) for weight loss and Depakote (medication approved for use in Bipolar Mania) 250 mg twice daily for Dementia. R11's PASRR (Pre admission Screening Resident Review) dated 10/7/25 documents The following information is important for the provider to know about your symptoms, behaviors, diagnosis or other related needs: you rarely speak, you are not oriented to yourself or your surroundings, you sometimes randomly laugh, no mental health symptoms noted by staff, staff states you used to sing several years ago, you no longer sing, you need help with problem solving and safety awareness and you were unable to participate in this interview. R11's Behavior Monitoring and Interventions report for 12/01/24 to present documents No behaviors observed. On 2/25/26 at 1:00 PM, V26 (R11's Legal Guardian) stated he had known R11 for years and states the resident does not have behavior issues. She was a very pleasant woman, loved to sing and (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was nice to a fault. V26 stated There would be no reason for (R11) to be on any mood-altering medications. For the past two years, she has been nonverbal and frail. She literally does nothing except lay in her chair. I never gave any consent for her to be medicated for behaviors. I would have said no because she does not need it.R11's Psychotropic Consent dated 11/24/25, documents the psychotropic medications to be administered as Depakote 250 mg (twice daily) for Dementia. V2 (Director of Nursing) signed it as verbal consent given. On 2/25/26 at 1:30 PM, V2 (Director of Nursing) could not provide any further details on R11's consent for Depakote. If I signed it that verbal consent was given, I would have spoken to him. V2 confirmed there was no progress notes or any other staff member who overheard V26 (R11's Legal Guardian) give consent for psychotropic medications. V2 confirmed that two nurse's signatures are usually obtained when obtaining verbal consent and then the paper is mailed to the family member/guardian. V2 could not provide a copy of the consent signed by V26. He must not have mailed it back.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to document discharge status for one resident of two residents (R71) reviewed for discharge in a sample of forty-one.Findings include:The Facility's Notice of Transfer and Discharge policy dated 10/2022 documents When the facility transfers or discharges a resident under any of the circumstances specified in reasons A through F above, the facility must ensure that the transfer or discharge is documented in the residents medical record and appropriate information is communicated to the receiving health care institution or provider. R71's Medical Record documents that he admitted to the facility on [DATE] with diagnosis to include cellulitis to both legs and need for assistance with wound care with a plan to go back home after legs were healed. R71's Medical Record documents that the wound doctor came to the facility on [DATE] and sent R71 to the emergency room for evaluation of wounds. R71's Medical Record does not document any further information including if resident was admitted to the hospital, expired or went home from the hospital. On [DATE] at 9:00 AM, V3 (Licensed Practical Nurse/ Assistant Director of Nursing/Infection Preventionist) stated Oh, I don't know what ever happened with (R71). You could go ask (R26/R71's spouse) who lives here, she would know. On [DATE] at 10:00 AM R26 stated that R71 discharged to a different facility after his hospitalization. R26 had no information about diagnosis, his current status or why he did not return to this facility after his hospitalization.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to update a care plan after an incident for one resident of twenty-four residents (R7) reviewed for care plans in a total sample of forty-one.Findings include:The Facility's Comprehensive Care Plan policy dated 1/2026, documents that each resident should have a comprehensive plan of care. The policy documents the care plan should be revised on an ongoing basis to reflect changes in the resident and the care the resident is receiving. R7's Medical Record documents that she was admitted to the facility on [DATE] with diagnosis to include but not limited to Dementia, Depression and Hypertension. R7's Nurse's Note documents on 2/12/26, R7 fell in her room. The documentation shows that R7 has a refrigerator in her room and she was attempting to get something out of the freezer and she hit herself in the head with the door and fell to the ground with no injuries. The Nurse's Note documents New Intervention: encourage resident to ask for assistance with her freezer due to unsteadiness. R7's current undated care plan documents that R7 is at risk for falls but does not contain any information about her fall on 2/12/26. On 3/3/26 at 2:00 PM V3 (Licensed Practical Nurse/Assistant Director of Nursing/Infection Preventionist) confirmed there was no mention of R7's fall on 2/12/26 on her care plan. It should be on there and it isn't.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to have supporting documentation for diagnosis for two of twenty-four residents (R10, R11) reviewed for justified diagnoses, in a total sample of forty-one.Findings include: 1. R10 was admitted on [DATE] with diagnosis of Post Traumatic Stress Disorder and Generalized Anxiety. The Brief Interview for Mental Status (BIMS) documents on 1/29/26, R10's cognition was moderately impaired and from 2/3/26 to present has been cognitively intact. The Preadmission Screening and Resident Review Level 1 dated 1/27/26, documents R10 did not have a Dementia or Alzheimer's Disease Diagnosis, and a Level 2 assessment was not required. V56's (R10's Family Physician) visit notes dated 12/30/25, 10/31/25 and 8/22/25, documents R10 had been evaluated for Dementia and passed the given test. No diagnosis of Dementia or Alzheimer's Disease were identified on the visit notes. R10's Elopement/Unauthorized Leave Risk review dated 1/29/26, documents R10 has a . history of or verbalizes a strong desire to leave-yes. Is there a history of dementia? No. The record did not include a Physician's Order to add a new diagnosis of Dementia. R10's record documents a Dementia diagnosis was added on 1/30/26 by V3 (Assisting Director of Nursing). The Minimum Data Set (MDS) dated [DATE] section I has Non-Alzheimer's Dementia listed as an active diagnosis. On 2/25/26 at 11:45 AM, V3 (Assisting Director of Nursing) stated she reviewed R10's admission documents and found a Dementia diagnosis and added it to the diagnosis list. Upon review of the admission documents, V3 verified the notes document R10 had a chief complaint of Dementia during a physician visit on 10/31/25, although it was ruled out with memory testing. V3 verified she did not obtain a physician's order for the Dementia diagnosis. On 2/24/26 at 11:18 AM, V55 (R10's family member and Healthcare Power of Attorney) stated My mom does not have Dementia or Alzheimer's. She lived independently until (Financial Power of Attorney) stole her house and sent her to the nursing home. On 2/26/26 at 10:21 AM, V54 (Family Physician's Certified Medical Assistant) stated R10 did not have a Dementia diagnosis and the facility had called two times today and requested the doctor to add and a Dementia diagnosis code to R10 diagnosis list. V54 stated That's not going to happen. On 2/26/26 at 10:40 AM, V39 (Medical Director/R10's Physician) stated many residents experience delirium the first 24-72 hours of admission. They (residents) get confused from taking them out of their environment. If the referring physician says R10 does not have a Dementia diagnosis, R10 doesn't have a Dementia diagnosis. 2. R11's Medical Record documents that she was admitted to the facility on [DATE] with diagnosis to (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	include but not limited to Alzheimer's, Conversion Disorder with Seizures and Hypothyroidism. R11's Physician Order Sheet documents a new Schizoaffective Disorder diagnosis dated 8/30/23. R11's Medical Record documents her first Psychiatrist visit on 12/3/24 and there was no mention of Schizoaffective Disorder. On 2/25/26 at 11:30 AM, V2 (Registered Nurse/Director of Nursing) stated she had no idea where the Schizoaffective Disorder diagnosis came from. V2 reviewed R11's medical record and confirmed there is no documentation of a history of Schizoaffective Disorder or any mental health diagnosis at all prior to 8/30/24. V2 confirmed there was no documentation of any unwanted behaviors for R11 in the past 2 years that were reviewed. On 3/3/26 at 1:00 PM, V26 (R11's Legal Power of Attorney) stated he had known R11 for years and had no information about any mental health diagnosis. V26 stated that R11 was a very nice and friendly person prior to her dementia. (R11) has no history of any mental health problems. R11's Clarification Nurse's Note dated 2/25/26 at 3:52 PM entered by V3 (Licensed Practical Nurse/Assistant Director of Nursing/Infection Preventionist), documents Spoke with (V53/Psychiatrist) he stated the diagnosis of Schizoaffective Disorder was before (this psychiatry group took over) and they removed the diagnosis from their diagnosis list.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assist and provide showers for three of twenty-four residents (R6, R43, R48) reviewed for showers, in a total sample of forty-one. Findings include: The Resident Council Meeting Minutes dated 1/7/26 documents residents still not getting showers. 1. R6's Medical Record documents he was admitted on [DATE] with diagnosis to include but not limited to Chronic Obstructive Pulmonary Disease (COPD), Type II Diabetes Mellitus and Right Lower Leg Cellulitis. R6's MDS (Minimum Data Set) dated 11/25/25 documents that he needs Partial/Moderate assistance with showering and bathing. On 2/24/26 at 10:16 AM, R6 was sitting in his recliner, hair appeared disheveled, was in just shorts, fingernails were long and jagged and he had facial hair. R6 stated he has been at the facility for approximately a year and has only had 5 showers. R6's admission was on 8/14/25 and first shower sheet noted was on 10/21/25 and states that resident gave himself a sponge bath. R6 had no documented showers given. R6 did have refusal of shower documented with two signatures on 10/23/25,10/28/25,11/7/25 and 11/11/25. 2. R43 was admitted on [DATE] with diagnoses of Metabolic Encephalopathy, Bipolar Disorder, Cerebrovascular Disease, Degenerative Disease of Nervous System, Major Depressive Disorder and Cognitive Communication Deficit. R43's current care plan documents R43 has an Activities of Daily Living (ADL) self-care deficit and requires substantial assistance with personal hygiene and oral care. On 2/24/26 at 10:30 AM, R43 stated she had not been getting her showers twice weekly and just didn't feel clean. The B Hall Shower Sheets 2nd Shift documents R43 is scheduled for showers each Wednesday and Saturday. R43's shower sheets dated December 2025 document one shower (12/13/25), January 2026 documents three showers (1/18/26, 1/21/26, 1/31/26) and February 2026 documents four (2/7/26, 2/11/26, 2/15/26, 2/18/26) were given. 3. R48 was admitted on [DATE] with diagnoses of Posthemorrhagic Anemia, Malignant Neoplasm of Cervix, Ovary and Uterus and a Cerebral Vascular Infarct. R48's current care plan documents R48 has an ADL self-care deficit and requires substantial assistance with personal hygiene and oral care. On 2/24/26 at 9:45 AM, R48 stated she had not been getting her showers twice weekly and felt sticky all over from being sweaty and lying in bed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The B Hall Shower Sheets 2nd Shift documents R48 is scheduled for showers each Tuesday and Thursday. R48's shower Sheets dated November 2025 document one shower (11/4/25), December 2025 has no documentation of showers, January 2026 documents five showers (1/18/26, 1/21/26, 1/23/26, 1/28/26, 1/31/26) and February 2026 documents two in Feb (2/3/26, 2/14/26) were given. On 2/24/26 at 3:00 PM V2 (Registered Nurse/Director of Nursing) stated that all residents should be given a shower twice weekly. V2 stated if a resident refuses to shower two staff members are to sign the bottom of the shower sheet and indicate why the resident did not want to shower. V2 provided all of R6's shower sheets since his admission.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assess, develop and implement a care plan and provide an ongoing program of activities based on residents' assessments and preferences for 2 of 4 residents (R51, R11) reviewed for activities in a sample of 41.Findings include:Findings include: The facility's Activities Program Policy, dated 1/2026, documents the purpose of the Activities Program is to provide an ongoing program of activities designed to appeal to the residents' interests and to enhance his or her highest practicable level of physical, mental, and psychosocial well-being. The guidelines outlined in this same policy document: the Activity Director, trained staff, or volunteer will: 1. Identify and involve each resident in an ongoing program of activities that is designed to appeal to his or her interests and needs, and 2. Enhance the resident's highest practicable level of physical, mental, and psychosocial well-being by offering a program of activities that provides the following: a. A heightened sense of well-being, b. Promotion of feelings of self-esteem, pleasure, comfort, education, creativity, success, and independence, c. That promotes educational or intellectual thought and requires thinking, d. Age and gender-specific, e. Produce something useful and provide purpose, f. Relate to previous work, g. Allow for socializing with visitors and participating in community events, h. Allow for opportunities for creativity and creative expression, i. Physically active programming, j. Produce or teach something, k. Religious activities, l. Opportunities for activities that contribute to the facility. 3. A minimum of 4-7 organized activities will be scheduled daily. 4. Provide programs for residents who will not, or cannot, effectively plan their own activity pursuits. This same policy states under the section, Activity Participation Records, the activity staff shall record residents' activity attendance and participation on a daily basis. The system used will record the activity attended, the resident's level of participation (active vs. passive) and whether the resident was invited to the activity but declined the invitation or had a conflict and was not available. The Activities Director and/or designee should review records to determine any emerging needs for resident assessment or care plan reviews. 1. R51's MDS (Minimum Data Set) assessment, dated 2/10/2026, documents in Section A an admission date of 4/17/2015; Section I documents R51 has Alzheimer's Disease, Non-Alzheimer's Dementia, and Parkinson's Disease; Section GG documents R51 is dependent on staff for all Activities of Daily Living (ADLs); and Section C documents R51 is rarely/never understood and no Brief Interview for Mental Status (BIMS) completed due to inability to answer BIMS questions. R51 was non-verbal and unable to communicate throughout the survey. R51's assessment titled, Activities - Quarterly/Annual Participation Review, dated 2/9/26, documents (R51) is non-verbal and low functioning due to her diagnosis of a stroke. (R51) is currently a 1:1 and will do small groups. V57 (R51's family member/Healthcare Power of Attorney) stated he comes just about every day to feed (R51). V57 pushes R51 through the building and stops to say hi to other residents and staff members. (R51) enjoys listening to music and holds onto soft things. R51's Care Plan, dated 2/19/26, documents a focus of: (R51's) preferences for activities are 1:1 with activity staff, sensory soft items, poetry, music and daily visits from V57. Goals:1. (R51) will maintain her current level of cognitive stimulation and socialization through the next review date and, 2. (R51) will participate in (R51's) preferred activities such as 1:1 sensory time, reading romance novels, and listening to music 3 times per week. Interventions listed in the care plan for this focus include: (R51) (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is a current 1:1 bedside/in-room visits with activities if unable to attend out of room events, (R51) needs assistance with ADLs as required during the activity, and (R51) needs assistance/escort to activity function. R51's Activities Preference Interview, dated 2/9/25, documents it is Very Important for R51 to do her favorite activities, including activities with groups of people and listening to music. R51's Activity Documentation, dated 11/27/25 to 2/25/26, documents R51 participated in a total of 4 activities (two documented activities as for movies and two documented activities as for music/entertainment) outside of documented activities of family visits and two documented activities of outings. Multiple random observations were made of R51 sitting in her wheelchair in her room alone with no music or television on or parked in her wheelchair in the common area facing the television from 2/24/26 to 2/27/26 between 8:00 AM and 3:30 PM. On 2/24/26 at 11:45 AM, V57 was present in R51's room sitting next to her and stated the Activities staff offered to read her a book every day, but that does not happen very often. She does not participate in any other activities, but V57 would like it if they offered more activities for her that she is interested in, and it would be good for her mind and overall well-being if she regularly participated in activities that were interesting to her. On 2/24/26 at 2:40 PM, V16 stated V57 is usually here after breakfast until after lunch. R51 gets laid down when V57 leaves after lunch to take a nap and then gets up for dinner. R51 does not usually participate in afternoon or evening activities. R51 gets up after her afternoon nap to go to dinner, eats dinner, and then, after dinner, we get R51 ready for bed. On 2/25/26 at 2:00 PM, R51 was observed sitting in her wheelchair in her room alone facing the window with no music or television on. V8/Certified Nursing Assistant stated R51 likes music and should have music playing while R51 is sitting in her wheelchair in her room alone. On 2/25/26 at 2:10 PM, V9/Activity Director stated R51 cannot actively participate in activities since she has Dementia. R51 likes romance novels read to her and soft animals for activities, as discussed with V57. These one-on-one activities are offered to R51 two times a week. R51's participation in activities should be documented by Activities staff each time she participates in an activity. 2. R11's Medical Record documents she was admitted to the facility on [DATE] with Alzheimer's, Dementia and Paranoid Personality. Throughout the survey R11 was nonverbal and appeared confused. R11's Activities Preferences Interview dated 1/20/26, documents Attempt to interview all residents able to communicate. If resident is unable to complete, attempt to complete interview with family member or significant other. All questions responses on the Activities Preferences Interview were marked as No response or non-responsive. R11's Care Plan dated 2/18/25, documents R11 is completely dependent on staff for intellectual, physical, emotional and social needs due to progression of Dementia. R11's Care Plan does not document any preferences for activities. (continued on next page)

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	03/03/2026

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/3/26 at 1:00 PM, V26 (R11's Legal Guardian) stated he had known R11 for years. V26 stated R11 was kind to a fault and loved singing and music. V26 stated he stops in to see R11 here and there and has never seen her in any formal type of activity. I don't know how much she understands anymore but it would be nice to see her around other (residents). R11's Activity Documentation for November 2025 until present February 2026 only lists Music and TV (television) as activities for R11. On 3/3/26 at 10:30 AM V36 (Activity Aide) stated that R11 usually is in her room by herself with the TV on to a show or music.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to do a urinary voiding trial as ordered for one of four residents (R8) reviewed for indwelling catheters, in a total sample of forty-one. Findings include:The Facility's Bowel and Bladder-Assessment and Toileting Programs policy dated 1/2026 documents The CNAs (Certified Nurse Aide) will document incontinent episodes on the Voiding Diary for 3 days as assigned. The incontinence data will be reviewed to try to identify a resident voiding pattern. The Restorative Incontinence Observation will be completed and an Incontinence/Toileting Program will be implemented based on the resident data and assessment as deemed appropriate. The resident's plan of care will be developed to address the issue(s), goals and appropriate interventions for elimination program, using an interdisciplinary team approach.R8's Medical Record documents that she was readmitted to the facility on [DATE] after a short hospitalization for Influenza and a Urinary Tract Infection. R8 returned with an indwelling catheter. R8's Physician Order Sheet dated February 2026 documents on 2/24/26 Remove (indwelling catheter) and implement voiding trial. On 2/25/26 at 2:10 PM, V16 (Certified Nurse Aide) and V17 (Certified Nurse Aide) assisted R8 to bed with a mechanical lift. R8's absorbent undergarment was dry. Both V16 (CNA) and V17 (CNA) denied any knowledge of the voiding trial or that they needed to track R8's urinary patterns for any reason. On 2/25/26 at 2:15 PM, V24 (Licensed Practical Nurse) confirmed she was the nurse responsible for R8's cares. V24 denied any knowledge of tracking R8's urinary output for any reason.

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	145442	A. Building B. Wing	03/03/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews and observation, the facility failed to ensure oxygen tubing was changed routinely for one of one resident (R55) reviewed for respiratory care, in a sample of 41.Findings include:The facility's Oxygen and Respiratory Equipment-Changing/Cleaning Policy dated 12/2025, documents nasal cannulas are to be changed weekly and as needed. R55's medical record documents R55 was admitted to the facility on [DATE] with diagnoses to include but not limited to: Chronic Obstructive Pulmonary Disease, Diabetes, Venous Insufficiency, Polyneuropathy, and Schizophrenia. R55's Physician Order dated 11/26/25, documents to change oxygen tubing weekly and as needed. On 02/24/26 at 9:48 AM, R55 was lying in bed with oxygen on at 2 liters via nasal cannula. R55's nasal cannula tubing was dated 02/14/2026 and the prefilled humidification bottle was dry and dated 02/14/26. R55 states I've asked to get that filled for two days, but they haven't done it and my nose is starting to dry out. On 02/24/2026 at 10:02 AM, V10 (Registered Nurse) reported the facility is out of prefilled humidification bottles for oxygen use. V10 reports oxygen tubing is to be changed weekly and is usually done on Sundays. V10 then provided R55 with a refillable oxygen humidification bottle. On 02/25/26 at 9:23 AM, V9 (Social Service Director) was in R55's room delivering his breakfast tray. V9 verified oxygen tubing is dated 02/14/26.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were safely administered for one of seven residents (R48) observed during the medication administration pass, in a sample of 41. Findings include:The Medication Administration policy, revised 4/22, documents Licensed Nurses may prepare, administer and record the administration of medications with the date, time and initials of the staff member who administered the medication; that residents may self-administer medication if the interdisciplinary team has determined that this is safe; Medications must be administered in accordance with physician's order to the right resident, right medication, right dose, right route and right time.R48 was admitted on [DATE] with diagnoses of Posthemorrhagic Anemia, Malignant Neoplasm of Cervix, Ovary and Uterus and Cerebral Vascular Infarct.R48's current care plan does not indicate R48 can self-administer medications. R48's record did not include a Physician's Order to self-administer medications. R48's Progress Notes do not include an Interdisciplinary Note that determined self-administration of medications were approved by the team. On 2/24/26 at 9:45 AM, R48 was asked why there was an empty medication cup on her bedside table. R48 stated the nurses leave her medications at the bedside and when she wakes up, she takes them.On 2/24/26 at 12:50 PM, R48 was observed resting in bed with the light out. Two medications were in a medicine cup sitting on her bedside table. R48 woke up, turned her light on and took her medications.The Medication Administration Record dated documents two medications (Gabapentin and Ropinirole) were administered on the lunchtime medication pass by V10 (Registered Nurse).On 2/24/26 at 1:15 PM, V10 stated R48 is alert and oriented and doesn't want to be woke to take her medications. V10 stated If the resident requests the nurse to leave the medications at bedside, I leave it (medications) there (at bedside).On 2/25/26 at 9:30 AM, V2 (Director of Nursing) stated R48's medications should not have been left at the bedside.