STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145623	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Morris	1095 Twilight Drive Morris, IL 60450

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility fail to revise and implement care plan interventions to prevent falls and provide safety for a resident identified as risks for falls. This applies to 1 (R47) of 3 residents reviewed for safety and supervision in the sample of 20.The findings include:R47 was admitted to the facility on [DATE], with multiple diagnosis including metabolic encephalopathy, acute cholecystitis, diabetes, lack of coordination, difficulty walking, cognitive communication deficit, muscle wasting, spinal stenosis, Parkinson's, history of falls and altered mental status. A nursing Progress note dated November 29, 2025, shows R47 was agitated following lunch and constantly moving via wheelchair through the halls. R47 was observed by staff bending over trying to fix attached footrest. R47 needed constant reminders to sit back in wheelchair to avoid falling. R47 bent forward in chair and was caught by nurse prior to falling to the ground. Per nurse R47 needed to be monitored at nurses' station and required constant queuing, reminding, and distractions for safety. One to one care was suggested. Progress notes from September 2025 to December 2025 show frequent episodes of agitation, restlessness, and behaviors that could have or resulted in a fall.On December 08, 2025, at 11:31AM, R47 was sitting in dining room in a high back wheelchair with four other residents including R13. There were no staff members present in dining room. R13 was sitting in a wheelchair nearby R47. R13 said that she watches over R47 when he is in the dining room because he gets up from his wheelchair and falls frequently. R47 was sitting at the edge of his wheelchair bending over and picking at the floor. R47 stood up from the wheelchair and attempted to lift his right leg over the right foot pedal. R13 called out to the nurses who were standing near a medication cart in the hall for help. R13 said that she often calls for help when this happens. R13 said there is not enough staff to sit with him, so she watches him. R47 attempted to stand and walk away from his chair at 11:39AM, 11:44AM, and 11:50AM. Each time R47 was redirected by R13 without the supervision of staff. On December 09, 2025, at 8:53AM, R47 was observed sitting in the dining room without supervision. R47 was sitting on edge of the wheelchair picking at the floor. Two puddles of clear liquid were noted on the floor behind the center of the wheelchair. There was also a puddle of light brown liquid noted on the floor near the right side of the wheelchair. There were no CNA's (Certified Nursing Assistants/CNA) or nurses in the nearby corridors or at the nurses' station. On December 10, 2025, at 9:55AM, R47 was observed propelling via wheelchair using his feet and holding on to objects along the way. R47's feet were placed under the footrest during this time. R47 stopped at the nurses' station. While sitting on the edge of the wheelchair, R47 bent over and began to pick at the foot pedals. R47 then continued to propel himself in his wheelchair using his feet. There were no nurses or CNAs at the nurses' station or in the corridors at this time. On December 10, 2025, at 10:08AM V16 (CNA) said that she was assigned to R47, and that staff observes them when they can, however this is hard to do as there are only two CNAs on the unit. V16 said that R47 had one to one care initially when he admitted to the facility, but that has since stopped as they no longer have the additional staff. V16 said that R47 does not engage in activities often and stays on the unit most of the time. On December 08, 2025, at 1:45PM, V19 (Family Member) said that R47 has had too many falls to count since being admitted to facility in September. R47's most recent fall was on December 07, 2025. V19 said she was informed that R47 would be kept at the nurses' station for supervision. V19 also said she is unaware of any additional interventions that have been put in place to prevent falls. R47's care plan dated September 29, 2025, shows R47 has impaired cognitive function and requires total assistance from staff for toileting, bed mobility, bathing, and transferring. R47's current fall care plan show's he experienced falls on September 29, November 14, November 19, November 26, December 04, and December 07 and does not include interventions for supervision/monitoring, fall risk behaviors, or personalized preventative interventions. An Active care plan dated September 29, 2025, shows R47 has impaired cognitive function and requires total assistance from staff for toileting, bed mobility, bathing, and transferring. R47's current fall care plan show's he experienced falls on September 29, November 14, November 19, November 26, December 04, and December 07 and does not include interventions for supervision/monitoring, fall risk behaviors, or personalized preventative interventions. The care plan interventions were not revised after fall incidents.On December 10, 2025, at 10:30AM, V20 (Care Plan Coordinator) said that she is responsible for putting fall interventions on the resident's care plans. V20 said if a resident continues to fall, it indicates that current interventions are not working. Interventions are adjusted as needed. On December 10, 2025, at 11:30AM, V2 (DON) said she is responsible for the Fall