

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145623	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/01/2026
NAME OF PROVIDER OR SUPPLIER Arcadia Care Morris		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview and record review, the facility failed to provide a resident with the daily cost of services no longer covered by Medicare in order for resident to make an informed decision whether they wish to continue receiving skilled services that may not be covered by Medicare and to assume financial responsibility. This applies to 1 of 4 residents (R4) reviewed for Resident Rights in a sample of 4. The findings include: R4's EMR (Electronic Medical Record) showed R4 ([AGE] years old) was admitted to the facility on [DATE], with multiple diagnoses including, displaced Maisonneuve's fracture of left leg, subsequent encounter for closed fracture with routine healing, other fracture of upper and lower end of left fibula, subsequent encounter for closed fracture with routine healing, other fracture of left lower leg, subsequent encounter for closed fracture with routine healing, unspecified fall, subsequent encounter, and difficulty in walking, not elsewhere classified. R4 was discharged from the facility on April 10, 2026. R4's MDS (Minimum Data Set) dated March 9, 2026, showed R4 was cognitively intact, had impairment on one side of her upper and lower extremities, and required maximum assistance with transfers. R4's care plan initiated on March 4, 2026, showed R4 had an Activities of Daily Living self-care deficit due to displaced fracture of the leg, fracture of the upper and lower ends of the left Fibula, unspecified fall, and other abnormalities of gait/mobility. Interventions documented, included PT (Physical Therapy)/ OT (Occupational Therapy) evaluation and treatment as per physician orders. R4's care plan initiated on March 16, 2026, showed, R4, will discharge/transfer to [home address] with six steps to enter the home. The care plan interventions were documented, and no concerns were noted. On June 1, 2026, R4 said the Medicare-managed insurance company ended her coverage for PT and OT services at the facility on April 9, 2026, denied her appeal, and told her she had to either go home with home health services or pay for the facility privately if she chose to stay. R4 said the facility did not provide her with a copy of the NOMNC (Notice of Medicare Non-Coverage) form she signed on April 7, 2026, and she did not know there was a phone number to call to file a complaint about the insurance denying her appeal. R4 said the facility later gave her a copy of the form on March 19, 2026, when she went to the facility with her advocate (V6) to express her concerns about the discharge process. R4 said the facility informed her she had the option to file a second appeal, but she refused. R4 also said she would have considered paying privately until her next orthopedic appointment to determine whether she could bear weight on her leg, but the facility did not provide her with the daily rates. R4 said she still did not know the daily rate until today (June 1, 2026). R4 said she was discharged from the facility on Friday, April 10, 2026, and her orthopedic appointment was on Monday, April 13, 2026. R4 said the orthopedic doctor discontinued her non-weight bearing status, and she was able to bear weight on the leg. R4 said she did not think the managed Medicare insurance company knew what they were doing, and the facility did not advocate for her with the insurance company. R4 said she had 24 hours of home health services because she could not transfer herself in the home. She spent a lot of money on home health services, which she could have used for the facility's private-pay fees if they had provided her with information about the private-pay cost. On June 1, 2026, V2 (Social Services Director) said R4's managed Medicare insurance company sent the NOMNC form to be issued to R4 on April 7, 2026, because R4's Medicare coverage would end on April (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9, 2026. V2 said he provided R4 with a copy of the NOMNC form. V2 said he offered R4 the option to pay privately and receive more therapy at the facility if she was willing, and R4 declined and opted to be discharged home. R4 said he did not provide R4 with the SNF ABN (Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage) form. V4 said he had not issued the SNF ABN form to any residents at the facility. V2 said he did not document any conversations with V4. On June 1, 2026, V5 (Financial Coordinator) said she completed the facility's admission contract with R4 on an electronic device, and that R4 signed it. V5 said the admission contract was over 100 pages, and one of the documents stated the facility's daily rate. V5 said she usually emails a copy of the contract to the resident's or representative's email on file with the facility, but did not email V4 the contract to V4. On June 1, 2026, V4 (Regional Social Service Coordinator) said V5 (Financial Coordinator) completes an SNF ABN with residents on admission to the facility. According to the EMR as of June 1, 2026, at 2:00 PM, the SNF ABN documented for R4, which was signed by R4, showed, Medicare does not pay for everything, even some care that you or your health care provider thinks you need. The Skilled Nursing Facility (SNF) or its Utilization Review Committee believes that the care listed below does not meet Medicare coverage requirements. Beginning on March 3, 2026 (R4's admission date), you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs. The care (s) you have been receiving during the Inpatient Skilled Nursing Facility include PT, OT, and Daily Skilled Nursing Care. These care (s) are no longer occurring daily. As a result, Medicare May Not Pay for your Inpatient Skilled Nursing facility due to the following reason (s): _____ [the line was left blank]. We estimate that these services will cost you \$ _____ [the line was left blank, no specific rate was listed] per day/item or service. Choose an option below about whether to get the care listed above. OPTIONS: Option 1 [selected] I want the daily skilled care listed above, which includes custodial services and room and board charges. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare does not pay, I am responsible for paying but can appeal to Medicare by following the directions on MSN. The document was signed by R4, and the date signed showed March 10, 2026. As of 2:00 PM on June 1, 2026, the facility could not provide documentation to show that R4 was provided with the SNF ABN form outlining R4's options, including notation of the daily rates at the time the NOMNC form was issued to R4. The facility's policy titled, Charges to Personal Funds Covered & Non-Covered Items with a revised date of January 2026 showed, Guidelines; The facility will inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate.		