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	07/02/2026

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 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 observations and interviews, the facility failed to provide residents with a clean and sanitary environment. This applies to 3 of 5 residents (R8, R12, R25) reviewed for Physical Environment in a sample of 37.The findings include:1. On June 30, 2026, at 2:15 PM, R12 was in her room. R12 had lots of crumbs on the floor and in the corners of her room. R12 also had brown stains on the hardwood floor, papers under her bed, and some brown powder on the floor next to her bed. V21 (Housekeeping) said she had already cleaned R12's room earlier the same day while R12 was not in her room. R12 said no housekeeping staff had been in her room to clean, and she had not left her room today. V20 (Housekeeping Director) said R12's room looked really bad and did not look like it had been cleaned by housekeeping on that day.2. On June 30, 2026, at 2:49 PM, R25 was lying in bed in her room. R25's room had lots of food crumbs all over the floor. R25's bathroom curtain had areas of black stains. R25 said her room only gets cleaned by the housekeeping staff about twice weekly, and they had not cleaned her room today. V20 (Housekeeping Director) said the black stains on R25's bathroom curtain looked like mold. V21 (Housekeeping) said she had already cleaned R12's room earlier the same day. V20 (Housekeeping Director) said R25's room did not look like it had been cleaned that day. 3. On July 1, 2026, at 10:16 AM, R8 was lying in bed. R8's room had lots of food crumbs, paper, and brownish-black stains on the hardwood floor. R8 said housekeeping does not clean her room daily, and she has to ask when she sees them cleaning nearby rooms. On July 1, 2026, at 11:30 AM, V1 (Administrator) stated that the facility's environment, including the residents' and dining rooms, is expected to be clean and sanitary. V1 also said there should not be black stains or mold on the residents' bathroom curtains for infection control and residents' dignity. V1 said every resident deserves to live in a clean and sanitary environment.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 provide nail care for residents who require assistance with activities of daily living (ADL) care. This applies to 5 of 5 residents (R10, R21, R31, R32, R33) reviewed for nail care in the sample of 37.The findings include: The following residents' active Minimum Data Set (MDS) showed that they all required assistance with grooming and hygiene. 1. On June 30, 2026, at 10:57 AM, R10 was resting in bed, she displayed long uneven fingernails nails with black/brown substances underneath the nails. V10 said she would like to have her nails clipped and cleaned. 2. On July 1, 2026, at 12:35 PM, R32 was resting in bed, she was observed with long dirty fingernails, with black/brown substances underneath nails. R32 stated she wanted staff to clean her nails, file them, or clip them slightly, but not too short. R32 said she was okay with staff to clean her nails. 3. On July 1, 2026, at 12:45 PM, R33 was resting in bed, she has long dirty fingernails, with black/brown substances underneath her nails. R33 stated that she would love to have her nails clipped and cleaned. 4. On July 1, 2026, at 12:57 PM, R34 was resting in bed. R34 has right side weakness due to stroke, she has contracture to her right hand and wrist. R34's fingernails were long, jagged, uneven, and with brown discoloration on her nail beds. R34 said she needed her fingernails to be clipped, especially her right fingernails. R34 showed her right index fingernail that was overgrown and curved at the tip of the index finger ([NAME] like). R34 also showed her the 3rd and 4th fingernails were digging in to the palm of her right hand. On July 2, 2026, at 11:19 AM, V2 (Director of Nursing/DON) stated that nail care is part of grooming care for the residents. 5. R21's care plan showed he had an ADL self-care performance deficit related to multiple diagnoses including limited mobility, history or pressure ulcer, type 2 diabetes mellitus with diabetic polyneuropathy, chronic kidney disease, and morbid obesity. Furthermore, it showed he required one person assist with personal hygiene. R21's Minimum Data Set, dated [DATE], showed he required substantial/maximal assistance for personal hygiene and grooming. On July 1, 2026, at 3:28 PM, R21's fingernails were long and filled beyond his fingertips with brown and black substances. R21 stated that he would like to have his fingernails cleaned and cut. R21 stated no one offers to cut or clean his fingernails. On July 2, 2026, at 3:07 PM, R21's fingernails were still long and filled beyond his fingertips with brown and black substances.

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F 0684 Level of Harm - Minimal harm or potential for 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 provide skin treatment/dressing change according to physician order for a resident who was identified with skin breakdown. This applies to 1 of 4 residents (R10) reviewed for wound treatment in the sample of 37. The findings include:Face sheet showed that R10 has multiple medical diagnoses including quadriplegia, multiple sclerosis, neuromuscular dysfunction of the bladder, weakness, hydronephrosis, cystostomy status, history of urinary tract infections (UTI), and muscle wasting and atrophy to multiple sites. On June 30, 2026, at 10:57, R10 was resting in bed, R10 stated that she has 2 urinary catheter one in her right lower back (nephrostomy tube) and in her abdomen (suprapubic catheter). On June 30, 2026, 11:30 AM, V11 and V12 (Both Certified Nursing Assistant/CNA) rendered incontinence care to R10 who was heavily saturated with urine and had a bowel movement. V12 stated that everyone (staff) knows that R10's catheters were both leaking. V11's buttocks were noted to be covered with fecal matter, which was pasty, and already adhered to the skin. There was a wound dressing on R10's buttocks which was dated June 27, 2026. This wound dressing was heavily saturated with urine and fecal matter and was almost detached from R10. R10's skin was reddish, purplish, macerated, soggy, and shriveled due to urine exposure for an extended period. V11 cleaned R10 with wash cloth, repeatedly due to the stickiness of the fecal matter. On June 30, 2026, at around 12:40 PM, V6 (Wound Care Nurse) stated V6 rendered wound care treatment to R10. V6 stated that R10's wound treatment and dressing change was ordered twice daily and as needed. V6 described R10's skin as moisture-associated skin damage (MASD). On July 2, 2026, at 1:19 PM, V30 (Wound Care Physician) stated R10 has recurrent dermatitis to her bilateral buttocks, and posterior thighs. Nephrostomy and supra have been leaking, that's why she got wet. They had been using steroid cream and Silvadene to apply to irritated peri-skin of the buttocks and exterior thighs. V30 ordered treatment for R10's buttocks collagen and gauze. R10 was heavily incontinent, that's why V30 ordered treatment twice a day and as needed. MASD and dermatitis were caused by constant exposure to urine and feces. V30's expectation was to keep R10's skin clean and dry and to follow his wound care order.R10's wound evaluation and management summary dated June 18, 2026, showed R10 has skin tear wound of the left, bilateral buttocks full thickness, with treatment to apply Collagen sheet twice daily and as needed if saturated, soiled or dislodge.R10's Braden Scale assessment dated [DATE], showed R10 was a high risk for skin breakdown.R10's care plan with revision date of May 19, 2026, showed R10 was at risk for skin impairment MASD (Moisture Related Skin Disorder) to bilateral buttocks related to fragile skin, incontinence, non-compliance with turning and repositioning, history of pressure ulcers, secondary to multiple sclerosis, muscle weakness, diaper dermatitis. This same care plan showed interventions including keeping skin clean and dry.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to ensure that indwelling urinary catheter and perineum care were provided in a manner that would prevent urinary tract infection (UTI). This applies to 4 of 4 residents (R10, R11, R15, R21) reviewed for catheter and perineum care in the sample of 37. The findings include:1. Face sheet showed R11 has multiple medical diagnoses including malignant neoplasm of the rectum, retroperitoneal abscess, colostomy status, type 2 diabetes mellitus, neuromuscular dysfunction of the bladder, muscle wasting, and obesity. Minimum Data Set (MDS) dated [DATE], showed R11 is alert and oriented and was totally dependent on staff for toileting and hygiene. On June 28, 2026, at 11:30AM and June 29, 2026, at 10:44 AM, R11 was observed lying in bed with indwelling urinary catheter draining to bedside bag that was cloudy yellow urine. Urinary tubing was unsecured with long clumps of solid sediments. On June 29, 2026, at 11:36 AM, R11 was lying in bed, her urinary catheter was draining with cloudy urine mixed with bright red blood. R11 stated that while the staff were cleaning her, she suddenly felt a sharp pain where the catheter was, she does not know why it suddenly hurt. R11 also said she has been hurting for a week now but during the provision of care it became more painful. On June 29, 2026, at 2:03 PM, V13 (Nurse) stated she was informed by CNA staff on duty that while they were taking care of R11 the catheter was slightly pulled causing the bleeding. V13 said she flushed the catheter and notified the physician. There was no anchor when she checked the catheter.On June 29, 2026, at 2:08 PM, R11's urinary bag was already emptied but there was still sign of bleeding in some of the urine. R11 verbalized that she still has pain/discomfort in her urethra and catheter remained unsecured. From June 30 to July 2, 2026, R11's urinary catheter remained unsecured or not anchored.2. Face sheet showed that R10 has multiple medical diagnoses including quadriplegia, multiple sclerosis, neuromuscular dysfunction of the bladder, weakness, hydronephrosis, cystostomy status, history of urinary tract infections (UTI), and muscle wasting and atrophy to multiple sites. On June 30, 26 11:30 AM, V11 and V12 (Both Certified Nursing Assistant/CNA) rendered incontinence care to R10 who had a pervasive urine odor. V11 stated that the last time she assisted R10 with incontinence care was at 6 AM. R10's frontal perineum, thighs, dressing to suprapubic and nephrostomy tubes were saturated with urine. The dressing of the suprapubic catheter and nephrostomy tube which was facing the skin was stained dark brown with urine and dated June 27, 2026. The suprapubic and nephrostomy tube were not anchored and dangling loosely. V12 stated that everyone knows that R10's catheters were both leaking. V11 cleaned R10's frontal perineum. As they turned V11 on her right side, V11's buttocks were noted to be covered with fecal matter, which was pasty, and already adhered to the skin. The incontinence pad and flat sheet were heavily saturated with urine which overflowed to the mattress. V11 cleaned R10 with wash cloth, repeatedly due to the stickiness of the fecal matter. V11 and V12 applied new incontinence brief, pad, and flat sheet, without cleaning the nephrostomy and suprapubic catheters. On June 30, 2026, at around 12:40 PM, V3 (Assistant Director of Nursing/ADON) and V6 (Wound Care Nurse) provided wound care and dressing change to R10's urinary catheters. When they started the catheter dressing change it was noted that there were still fecal matters that were on R10's right hip that were not totally cleaned off.3. Face sheet showed R21 has multiple diagnoses including type 2 diabetes mellitus, stage 3 B chronic kidney disease, polyuria, urinary retention, and morbid obesity. Minimum Data Set (MDS) dated [DATE], showed R21 was alert and oriented and requires substantial/maximal assistance for toileting and hygiene.On June 30, 2026, at 1:45 PM, R21 was noted with urinary catheter. R21 stated he needed someone to change his incontinence brief because he had a bowel movement before lunch time. V11 (CNA) was informed but she stated she was still busy. On June 30, 2026, at 2:00 PM, R21 said that his incontinence brief has not been changed yet. V11 already left and V14 (evening CNA) was informed. At 2:30 PM, V14 rendered (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incontinence care to R21 who had a bowel movement. R21's mid perineum was moist with redness and some open skin. V14 cleaned R21's back perineum and applied new brief without cleaning his frontal perineum and urinary catheter. 4. Face sheet showed that R15 has multiple medical diagnoses including type 2 diabetes mellitus and morbid obesity. MDS dated [DATE], showed R15 was alert and oriented and was totally dependent on staff for toileting and hygiene. On July 1, 2026, at 1:12 PM R15 was in her bedroom sitting on her reclining wheelchair. R15's pants and the bottom part of her blouse were wet with urine. R15 stated she needs assistance to go back to bed and change her pants and incontinence brief. R15 also said that her incontinence brief was changed early that morning and since then, R15 had two bowel movements and voided several times. R15 has been asking staff to change her incontinence brief.On July 1, 2026, at 1:16 PM, V12 and V19 (Both CNA) rendered incontinence care to R15 who was heavily saturated with urine and bowel movement. V12 used wash cloth to wipe R15's perineum from front to back. However, V12 did not clean R15's labial folds, urethra, and the inner folds of the groins. On July 2, 2026, at 10:43 AM, V2 (Director of Nursing/DON) stated when staff are providing catheter and incontinence care, expectation is to clean the catheter at least once every shift and as needed to prevent infection. The catheter should be secured to prevent being pulled or dislodged. It was not in the policy, but it was part of the management and protocol to ensure that the urinary catheter tube is secured. When providing peri-care, the staff must ensure that the full peri-care from front to back is cleaned. For female resident they should clean the whole vulva including labial folds and groins, check and change the resident for incontinence every 2 hours and as needed to prevent urinary tract infection (UTI). Facility's Incontinence Care Policy dated January 2026 showed: Purpose: To prevent excoriation and skin breakdown, discomfort, and maintain dignity. Guidelines: Incontinent resident will be checked periodically in accordance with the assessed incontinent episodes or approximately every 2 hours and provided perineal and genital care after each episode. Procedure: In the female, separate labia wash with strokes from top downward (with gloved hands), each side separately with a clean cloth. Keep labia separated with one hand. Wash labia first then groin areas.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide sufficient staffing in accordance with its facility assessment tool and residents' care needs. This applies to 3 of 3 (R1, R31, R34) residents reviewed for sufficient staffing in a sample of 37.The findings include:1.R1's Face sheet showed R1 was admitted to the facility on [DATE]. R1 had multiple diagnoses, including multiple sclerosis, trigeminal neuralgia, convulsions, malnutrition, mitral valve insufficiency, depressive disorder, hypoxemia, chronic obstructive pulmonary disease, constipation, anxiety, hypotension, and epilepsy.R1's minimal data set (MDS) dated [DATE], indicated that R1 was cognitively intact and dependent on staff for activities of daily living (ADLs).On June 28, 2026, at 10:33 AM, R1 said the census is low and that staff are being cut. R1 believes this directly affects the care residents receive. R1 feels she is not receiving quality care. R1 reported an instance in which she sat in feces for 45 minutes because no one on the floor could assist her at the time. R1 believes this caused her current urinary tract infection (UTI). R1 said that if a call button is pushed during meal times, the resident will have to wait until the meal is complete because the aides are all feeding residents and no one is available to respond.On June 30, 2026, at 8:56 AM., V18 (Registered Nurse/RN) responded to R1's call button. R1 informed V18 that she needed to be changed. V18 informed R1 that she would have to wait until her (Certified Nursing Assistant/CNA) finished feeding residents, since V18 was in the middle of passing medications. R1 asked whether another CNA was available to assist her. V18 informed R1 that no one else was available, as all CNAs were currently feeding residents.2.R31's Face sheet showed R31 was admitted to the facility on [DATE]. R31 had multiple diagnoses, including hemiplegia, chronic pain, depression, and falls.R31's MDS dated [DATE], showed that R31 was cognitively intact. R31 was dependent on staff to complete activities of daily living.On June 28, 2026, at 10:21 AM, R31 said that the facility is short-staffed. R31 said the CNAs are stressed and cannot perform their jobs as they should. R31 said they can only do so much, and as a result, the residents are not receiving the care they need.3.R34's Face sheet showed that R34 was admitted to the facility on [DATE]. R34 had multiple diagnoses, including malignant neoplasm, dementia, diabetes, anxiety, and hypertension.R34's MDS dated [DATE], showed R34 was cognitively intact and required moderate assistance from staff to complete activities of daily living.On June 29, 2026, at 9:00AM, R34 said she feels the staff is sometimes short-staffed. R34 said there are many residents and few staff.On June 29, 2026, at 12:50 PM, V17 (CNA) stated that whenever she is on the schedule, she works in the villa alone. V17 stated that she was informed that no other CNA would be in the villa until the census was above 18. V17 stated that ten residents require two-person assistance with transfers. V17 stated that if the nurse is too busy to assist, she must wait until someone from another unit can come down to assist. V17 stated that she has discussed concerns with V3 (Assistant Director of Nursing/ADON). V17 stated that V3 informed her that V3 would discuss the issue with V2 (Director of Nursing).On July 01, 2026, at 11:46 AM, V15 (CNA) was asked whether there were enough staff at the facility and whether the problems they encountered were due to a lack of staffing. V15 said he has been working at the facility for 4 years and feels it is not well-staffed. In the Villa, there's only one person (CNA) working; the administration informed them that if there were fewer than 18 residents, they could have only one CNA. V15 also said they are trying to do the best they can, but he feels their best does not meet the expected standard of care due to insufficient staffing. V15 said that all the problems happening are due to a lack of staff. It doesn't give them (CNAs) the chance to help one another; there are not enough people monitoring and assisting with toileting, which is why people would go to the toilet by themselves, and incidents happen.On June 30, 2026, at 9:02 AM, V16 provided care for R1. V16 said she was supposed to be on break; however, staff rarely have time to take one. V16 said the morning shift had to change several residents who were (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	soaked in urine because there was not enough staff overnight.On June 30, 2026, at 9:45AM, V11 (CNA) reported that hours have been cut short, which is causing a lack of care for the residents. There are not enough staff members or time to complete all tasks. V11 said that sometimes they are canceled on their scheduled days and sent home.On July 01, 2026, at 10:58 AM, V16 (CNA) reported that management has been cutting hours due to the low census. Residents don't receive proper care because the staff is short-staffed. Administrative staff set staffing levels based on what they believe is needed; however, this does not reflect residents' needs. The increase in fall incidents can be attributed to a lack of staffing. They used to have an extra staff member responsible for monitoring the hallways and bedrooms and answering call lights, especially during mealtime, when everyone is busy passing trays and setting up meals for residents.On July 01, 2026, at 11:53 AM, V19 (CNA) stated that she had been working at the facility for two weeks. V19 said she doesn't feel there are enough staff assigned to each shift. V19 said she has a heavy hallway, and half of her residents needed extensive assistance from 2 staff members. A resident had to wait a long time for help because everyone was busy, which delayed care for the residents. The care was completed, but it wasn't timely.On July 01, 2026, at 12:16 PM, V27 (CNA) reported that the facility is short-staffed. V27 stated that residents' care is affected because tasks are not always completed as scheduled. V27 also noted that it can take at least 25 minutes to respond to a call light, depending on the level of care a resident in another room is receiving. If a resident needed to use a mechanical lift, she would often have to wait until someone was available to help her. On July 01, 2026, at 3:30 PM, V32 (CNA) was exiting a residence room alone using a mechanical lift. V32 stated that she used the mechanical lift alone because no additional staff was available to assist. V32 further stated that the resident required two-person assistance and an additional person to operate the mechanical lift, but there was not enough staff present to do so.On July 2, 2026, at 11:50 AM, V2 (Director of Nursing) stated that he would like additional nurses and CNAs on the floor; however, he was informed that the current scheduling system needed to be implemented. V2 said he was told to cancel staff if the census drops. Upon reviewing the assessment tool, V2 noted that the facility is understaffed, with only 6 CNAs scheduled for the day and evening shifts, when 8 are needed. V2 said the schedule was changed from May to June due to a decrease in census. A review of the facility's fall list showed an increase in unwitnessed falls from May to June of 2026. There were three falls in May and fifteen in June.The facility's assessment tool indicated that the day shift should be staffed with 1 (Registered Nurse/RN), 2 (Licensed Practical Nurses/LPNs), and 8 CNAs. The evening shift should include 3 LPNs and 8 CNAs, and the night shift should include 3 CNAs and 2 additional staff members.The facility's nursing schedule was reviewed for the period from June 2026 to July 3, 2026. There were no days with 8 CNAs assigned to the day or evening shift. The day shift was typically scheduled with 5-6 CNAs. On June 11, 2026, the day shift was scheduled with 7 CNAs and 1 CNA for a 1:1. A note next to two names read, If all show, go home. This left only 5 CNAs on the floor to care for residents. On June 20, 2026, 3 CNAs covered the 100-400 units, and 1 CNA covered the villa. One CNA called off and was not replaced on the schedule.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow standard infection control practices with regards to hand hygiene and gloving, placement of urinary drainage bag, soiled linen and clothes, and not wearing complete personal protective equipment (PPE) when providing care for residents under enhance barrier precautions (EBP). This applies to 10 of 10 residents (R1, R7, R10, R11, R12, R13, R15, R21, R28, R29) reviewed for infection control in the sample of 37. The findings include: 1. On June 30, 2026, R12's room door had an EBP (Enhanced Barrier Precautions) sign on the door stating that Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: wear gloves and a gown for the following: high-contact resident care activities, dressing, transferring, and changing linens. The fitted sheet on R12's bed was soiled with stool. V27 and V28 (Certified Nursing Assistant/CNAs) came into R12's room to change R12's bed linens without wearing gowns. V27 and V28 were wearing gloves. V27 and V28 removed the soiled bed linens and applied clean bed linens without disinfecting the mattress. Additionally, V27 and V28 did not perform hand hygiene before exiting R12's room. 2. On July 1, 2026, R28 had an EBP sign on the door stating Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: wear gloves and a gown for the following: high-contact resident care activities, dressing, transferring, and changing linens. V23 (Nurse) and V17 (CNA) entered R28's room and transferred R28 to bed without wearing gowns. On July 1, 2026, R28 said the facility staff members are supposed to wear a gown to protect his suprapubic catheter, but most of the time they do not. 3. On July 1, 2026, R29 had a sign on her door stating, STOP. CONTACT PRECAUTIONS. EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS MUST ALSO: Put on gloves before entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. V23 (Nurse) went into R29's room without wearing PPE (gown and gloves). V23 exited R29's room, returned to the medication cart outside R29's room, and touched items on and inside the cart without performing hand hygiene. 4. On June 28, 2026, at 12:40 PM, V33 (licensed practical nurse/LPN) performed wound care on R7. V33 entered R7's room and donned gloves without performing hand hygiene. V33 removed the old dressing from R7's right leg. V33 removed gloves and donned a new pair without performing hand hygiene. V33 cleansed the area with saline solution and applied a new dressing while wearing the same soiled gloves. V33 removed the soiled gloves and exited the room without performing hand hygiene. On July 1, 2026, V23 went into R7's room after exiting R29's room without performing hand hygiene. V23 checked R7's blood pressure without performing hand hygiene and exited the room without performing hand hygiene. V23 returned to the medication cart and touched different surfaces on and inside the medication cart without performing hand hygiene. V23 then returned to R7's room to administer medication. V23 exited R7's room without performing hand hygiene. V23 walked out of the resident's room with a cup of water, walked to the soiled utility room down the hallway, opened the door, and returned to the resident's room without performing hand hygiene. On July 2, 2026, V2 (Director of Nursing/DON) said that all staff providing direct care, such as transferring, showering, changing linens, and toileting residents, on EBP precautions are required to (continued on next page)

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	07/02/2026

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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wear a gown and gloves. V2 said staff are required to use hand rub sanitizer, wear gowns and gloves before entering the rooms of residents in contact isolation precautions, and perform hand hygiene after exiting the room. V2 said staff must perform hand hygiene between all residents and before and after entering and exiting residents' rooms. V2 also said good hand hygiene is the number one prevention of infection and cross-contamination. 5. On June 30, 2026, at 10:57, R10's bedroom has a strong urine odor. R10's nephrostomy tube/catheter bag was inside a basin that was resting on the floor. The nephrostomy bag was leaking with urine that had formed into a gel-like sedimentation. On June 30, 26 11:30 AM, V11 and V12 (Both Certified Nursing Assistant/CNA) rendered incontinence care to R10 who was saturated with urine and had a bowel movement. V11 cleaned R10's perineum from front to back, while V12 assisted R10 to change incontinence brief, pad, and linen. They placed the soiled items inside a plastic bag and left the bedroom. V11 and V12 did not perform hand hygiene in between tasks and before leaving the bedroom. On July 1, 2026, at 10:45 AM, V11 (CNA) stated R10's nephrostomy catheter bag has been in the basin for about 2 months now, because the catheter has been leaking. V11 was not sure if the tube or the bag was leaking. The nurses knew about the nephrostomy bag on the floor and the leaking 6. On June 30, 2026, at 11:18 AM, there was an EBP signage posting outside R21's door due to his urinary catheter. On June 30, 2026, at 2:30 PM, V14 rendered incontinence care to R21 who had a bowel movement. V14 cleaned R21's back perineum, applied new brief, and straightened linen, wearing the same soiled gloves all throughout the care. V14 also did not wear a gown and did not perform hand hygiene in between tasks during the provision of care. 7. On July 1, 2026, at 1:16 PM, V12 and V19 (Both CNA) rendered incontinence care to R15 who was heavily saturated with urine and had a bowel movement. V12 cleaned R15 from front to back of the perineum, applied new incontinence pad, and put a new set of pants on R15 while wearing same soiled gloves all throughout the care. 8. On July 2, 2026, at 10:00 AM, V16 (CNA) provided perineum care to R11. R11 has an indwelling urinary catheter. V16 Cleaned R11 from front to back, applied new brief, and helped repositioned R11. V16 donned full PPE, she changed gloves in between tasks, however, she did not perform hand hygiene in between changes of gloves and tasks. On July 2, 2026, at 11:13 AM, V2 (Director of Nursing/DON) stated that when providing care for a resident on EBP the staff should be wearing gowns and gloves. When they are rendering peri-care they should perform hand hygiene and change gloves before and after care, and in between tasks from dirty to clean, and before exiting the room to prevent spread of infection. The staff should place soiled linen and clothes in a plastic bag and not on the floor. The urinary bag should be positioned below the bladder and should be hanging and not touching the floor as part of infection prevention. 9. On June 30th, 2026, at 9:02 AM, V16 (CNA) performed care on R1. V16 entered R1's room and donned gloves. V16 removed R1's soiled brief and cleansed R1's perineal area with wipes. Using the same soiled gloves, V16 applied a new brief to R1. Using the same soiled gloves, V16 moved R1's bedside table closer to her. V16 removed trash from R1's room and tossed it into a trash bin located in (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a resident's room diagonally across from R1's room. V16 removed gloves. V16 did not wash or sanitize her hands after performing care. 10. On June 29th, 2026, at 10:31 AM, R13 exited his bedroom in search of a CNA. R13 was experiencing diarrhea, which was leaking from his wheelchair and dripping along his bedroom floor and out toward the doorway. V34 (CNA) and V35 (CNA) responded to R13's call button and prepared to provide care. V35 obtained bleach wipes to clean the spill on the floor. V34 entered R13's room and donned gloves without performing hand hygiene. V34 gathered towels and warm water from the bathroom, placing them in a basin. V34 returned to the bedroom and removed a soiled gown from R13. V34 placed the soiled gown and other soiled garments on the floor next to R13's dresser. V34 removed soiled gloves and put on new gloves without performing hand hygiene. V34 removed R13's soiled brief and cleansed R13 with soap and water. V34 dried R13 with a towel. With the same gloves, V34 applied a new brief to R13. V34, still wearing the same gloves, continued to straighten items in R13's room before removing gloves and exiting the room without performing hand hygiene. The facility's Hand Hygiene/ Hand Washing policy, dated August 2026, states that soap and water are recommended for cleaning visibly dirty hands. Examples of when to perform hand hygiene include before eating, before and after having direct contact with the patients intact skin, after contact with blood body fluids or excretions, mucous membranes, non-intact skin, or wound dressings, after contact with inanimate objects in the immediate vicinity of the patient, if hands will be moving from a contaminated body site to a clean body site during patient care, before glove placement, after glove removal, and after using a restroom. The facility's titled Hand hygiene/Handwashing policy with an effective date of January 2026 showed Examples of When to Perform Hand Hygiene (Either Alcohol Based Hand Sanitizer or Handwashing): Before and after direct contact with a patient's intact skin taking a pulse or blood pressure, performing physical examination, lifting the patient in bed). After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. If hands will be moving from a contaminated-body site to a clean-body site during patient care. Before glove placement. After glove placement. The facility's titled Enhanced Barrier Precautions with an effective date of December 2025, showed, Policy: . Personal Protective Equipment. 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.