

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145811	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care Peoria Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 1629 East Gardner Lane Peoria Heights, IL 61616	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145811	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care Peoria Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 1629 East Gardner Lane Peoria Heights, IL 61616	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to prevent resident-to-resident physical abuse and staff-to-resident verbal abuse for four of four residents (R1, R2, R3, R4) reviewed for abuse in a sample of four. Findings include: The facility's Abuse Prevention and Reporting policy, reviewed 09/2024, documents that this facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds. To residents within hearing distance, regardless of age, ability to comprehend, or disability. A resident-to-resident altercation should be reviewed as a potential situation of abuse. Resident-to-resident altercations that include any willful action that results in physical injury, mental anguish, or pain must be reported in accordance with regulations. 1. The facility's Final Abuse Investigation Report, dated 10/23/25, documents that at approximately 7:00 pm on 10/19/25, the facility Administrator was informed of what appeared to be a physical altercation between (R1) [Diagnosis: Anxiety disorder, Major Depression disorder, chronic pain, BIMS (brief interview for mental status) 15 (cognitively intact) and (R2)] the incident occurred in the smoking area and dining room. V4 Receptionist heard verbal disagreement between both residents. Both residents were assessed, and R2 was noted to have a hematoma above the right eye. R1's witness statement, dated 10/20/25, documents that (R2) came into the building staggering, being loud. (R2) asked me (R1) for a light, which I gave him. I seen (sic) the knot on his eye and asked him if he fell while he was out. (R2) said he was going to stab me when I was walking off. I took my jacket off and chest bumped him, who swung on me. I pushed him back and got my foot around his ankle, and he fell on the couch. On 12/10/25 at 11:00am, R1 stated that he and R2 were arguing on the smoking patio, then R2 went back into the building. R1 stated that he was walking back to his room when R2 continued to talk crap to me. R1 stated that he pulled his shirt off and ran towards him. R1 stated that he chest bumped R2 and he fell to the ground. On 12/11/25 at 9:40am, R2 stated that he was arguing with R1 on the smoking patio, then he went back inside and waited for him to come in. R2 stated that R1 came running at him and chest bumped him, and he fell to the ground. R2 stated that he did not remember what they were arguing about. On 12/11/25 at 10:15am, V4 (Receptionist) stated that R1 and R2 were arguing during the smoke break, which she thought was over. R1 was walking towards the hall to go to his room, then turned around, took his shirt off, and went after R2. V4 stated that R1 chest bumped R2. R2 tried to swing at R1, R1 pushed R2, and he fell. V5 (Certified Nursing Assistant) stated that R1 and R2 were separated. 2. The facility's Final Abuse Investigation Report, dated 11/25/25, documents that at approximately 6:50pm on 11/20/25, V1 (Administrator) was notified of an alleged physical altercation between (R3) and (R4). All the required parties were notified. R4's Alleged Victim-All Abuse Types, dated 11/26/25, documents I let (R3) borrow my phone. He wouldn't give it back. We started arguing. I threw my plate at him and punched him. R3's Alleged Victim-All Abuse Types, dated 11/26/25, documents I borrowed (R4's) phone. I gave it back, but he didn't think so. He was yelling at me accusing me of stealing it. He threw a plate at me and hit me. On 12/11/25 at 10:30am, V5, Certified Nursing Assistant, stated that she heard R3 and R4 arguing in their room. V5 stated that she was in their room, searching for R4's phone, when R4 threw a plate at R3, then went after him and hit him. V5 stated that R3 did hit R4 back. V5 stated that she yelled for help and other staff came in the room to help separate the two. V5 stated that the phone was later found in R4's possession. 3. The facility's Preliminary 24-hour Abuse Investigation Report, dated 12/8/25, documents that it was reported that (R1) and a staff member (V4) had a verbal disagreement. The staff member was suspended immediately. All parties were notified. On 12/11/25 at 11:00am, R1 stated that he was coming back into the building from an outing and was talking to a visiting Pastor when (V4) started to yell at me because she had to get up from the desk and let us in. She told me she was not letting me back in if I went outside to smoke. She was cussing at me, then started talking crap about my mom, and that's when I started yelling at her back. R1 stated that there was another staff member there who broke it up. On 12/11/25 at 10:30am, V5 (Certified Nursing Assistant) stated that she was going to the receptionist desk to pick up her food delivery. V5 stated that she heard V4 (Receptionist) yelling at R1, telling him he could not go out anymore, even though R1 had an independent pass. V5 stated that V4 called R1 stupid and was making comments about R1's mother. V5 stated that she told her to stop; she could not speak to him that way. V5 verified that she told the nurse, and V4 was sent home</p>		