STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145811	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Peoria Heights	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. Based on observation, interview, and record review the facility failed to prevent resident to resident abuse for 2 residents (R24, R44) of 2 reviewed for abuse in a total sample of 40 residents.The Facility Reported Incident with finalization date of 12/31/25 documents on 12/25/25 at 5:55 PM V6, V8 (both Licensed Practical Nurses/LPN) and V9 (Certified Nursing Assistant/CNA) heard yelling coming from R44's room. When V6, V8, and V9 entered the room, R24 and R44 were hitting each other. The two residents were separated and assessed for injuries. R24 and R44 did not have any injuries. The Facility Reported Incident documents that R24 and R44 are both cognitively intact. On 1/6/26 at 10:12 AM R44 reported R24 was disrespectful to him and would not go into further detail.On 1/6/26 at 10:20 AM R24 reported R44 had his music loud and R24 asked R44 to turn it down. R44 did not turn his music down and R24 turned music off. R24 stated R44 then hit him in the face twice, but did not cause any injury. R24 stated he was then moved to a different hall.On 1/7/26 8:39 AM V6 (LPN) stated she heard a commotion and went to R44's room and separated residents. R44 and R24 were both in their wheelchairs at the time. V6 was not sure if R44 had his music loud. V6 verified R44 and R24 were not roommates at the time, but did live on the same hallway.On 1/7/26 at 10:16 AM V8 (LPN) reports when she entered R44's room, R44 and R24 were each in their wheelchairs and were punching each other. V8 reports she did not hear R44's music playing prior to incident.

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement restorative therapies and interventions to prevent contracture for one (R64) of two residents reviewed for positioning and mobility in a sample of 40.Findings include: The facility policy titled, Restorative Nursing Program, last approved 12/2025, documents not in its entirety, Purpose: To promote each resident's ability to maintain or regain the highest degree of dependence as safely as possible. Includes, but not limited to, programs in walking/mobility, dressing and grooming, eating, and swallowing, transferring, bed mobility, communication, splint or brace assistance, amputation care and continence programs. Guidelines: Each resident will be screened for restorative nursing upon admission, annually, quarterly, and with any significant change in function; Appropriateness for a restorative program will be determined by the interdisciplinary team as needed and/or may be determined as a continuation of care following a course of physical, occupational and/or speech therapy; Each resident involved in a restorative program will have an individualized program with individualized goals and measurable objectives documented on the plan of care; Documentation of the interventions and the resident's response will be completed with each implementation. Identify residents who currently have splints/braces or previous range of motion programs or those that have actual or potential limitations with ROM (Range of Motion) and/or pain. R64's admission Record documents R64's date of admission to the facility was 6/6/23 and her diagnoses include but not limited to Hemiplegia and Hemiparesis following other Cerebrovascular Disease Affecting Left Non-Dominant Side, Chronic Obstructive Pulmonary Disease, Seizures and Heart Failure. R64's Minimum Data Set (MDS) assessment dated [DATE], documents that R64 has a Brief Interview for Mental Status score of 15/15 indicating cognition intact, has functional limitation in range of motion to upper and lower extremity on one side, is dependent with dressing, hygiene and transfers and is not in Restorative Nursing Program. R64's current care plan as of 1/6/25 has no documentation regarding her contracted left hand and no interventions to prevent further decrease in range of motion. R64's Restorative Observation assessment dated [DATE] documents R64 is not receiving Restorative Programs for PROMS (Passive Range of Motion) or AROM (Active Range of Motion). On 1/7/25 at 9:44 AM R64 is lying in bed with her eyes closed and noted to have a contracted left hand. On 1/7/25 at 11:14 AM R64 stated she has minimal movement in her left hand, and they currently are not doing anything for it. On 1/09/2026 8:37 AM V1 (Administrator) stated that they have no documentation regarding attempting any form of Restorative Rehab for R64. V1 (Administrator) also stated, We have documentation showing she (R64) refuses cares frequently but nothing that pertains to Restorative Care. We did implement Restorative tasks for the CNA's (Certified Nursing Assistant) yesterday and today but up until then we had not been doing anything.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview and record review, the facility failed to ensure the medication cart was locked and medications were secured. This has the potential to affect all 23 (R4, R6, R7, R15, R29, R30, R32, R34, R41, R43, R50, R53, R54, R63, R64, R67, R68, R70, R75, R88, R89, R95, and R97) residents who reside on the hallway where the incident occurred.Findings include:The facility policy titled, Medication Storage, last approved 12/2025, documents not in its entirety, Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors.The facility policy titled, Medication Administration Policy, last approved 10/24, documents not in its entirety, Medication Storage Areas (medication room, medication cart, and treatment cart) must be locked when not in use by authorized personnel. Authorized personnel include licensed nurses, CMA (Certified Medication Aide) and the facility's pharmacists. Any other individual needing access to a medication storage area must be supervised by an authorized person while in the medication storage area.The Resident Room Roster dated 1/6/26 documents 23 residents reside on the XXXXX Hall.On 1/7/26 at 10:30 AM, V4 (Registered Nurse/RN) left a medication cart unlocked in the hallway across from room YY on XXXXX Hall when going to check R53's blood sugar leaving medications accessible to residents, staff, and visitors.On 1/7/26 at 10:35 AM when asked if the medication cart should have been locked prior to going into R53's room, V4 (RN) stated, It was locked, I always lock my med (medication) cart. Then when asked why he did not use his keys to open the cart when coming back out of R53's room to obtain her (R53) insulin V4 (RN) became flustered and stated, I guess I messed up. (referring to medication cart being unlocked).On 1/7/26 at 10:40 AM V2 (Director of Nursing) stated, Medication carts should always be locked when the nurse is leaving the cart. There should be nothing accessible on top of it such as medications, needles, or the keys.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure hospice communication was coordinated and the required documents were available and accessible to the facility staff. This deficiency affects one of one resident (R10) reviewed for hospice care management in a sample of 40 residents. Findings include:The Hospice Services policy dated 11/2012 documents the facility shall honor the advanced directives and care alternatives residents may desire when terminally ill and to afford residents with care that allows for dignity and comfort during the end stage of their lives. Hospice service will conduct assessments and develop a hospice plan of care which will be integrated with the resident's overall plan of care and maintained in the medical record or other location with the interdisciplinary care plan. All hospice service staff will write a progress note for each resident visit indicating treatment provided and pertinent information related to the resident's condition which is available for all interdisciplinary staff to access. Hospice service staff will attend care plan conferences and participate in the resident's care planning process. The Hospice Service Agreement dated 7/1/25 documents for each hospice resident, the facility will develop a facility care plan which is consistent with his/her Hospice care plan. For each hospice resident, the hospice will develop a Hospice care plan and furnish a copy to the facility. Communication between the hospice and facility shall be conducted weekly and/or at each resident visit and documentation of such communication shall be included in the medical record. R10 admitted on [DATE] and elected Hospice benefits on 11/28/25 with terminal diagnoses of Dementia, Congestive Heart Failure, Protein Malnutrition, Paranoid Schizophrenia and Traumatic Brain Injury. R10's current Care Plan lacked specific Hospice responsibilities/interventions. R10's medical record lacked a Hospice Plan of Care, Election forms, Physician Certification of Terminal Illness and/or copies of clinical notes. R10 Physician's Order for Life Sustaining Treatment (POLST) dated 10/9/23 documents R10 requested to attempt full cardio-pulmonary resuscitation and full treatment including mechanical ventilation and cardioversion to be conducted/attempted. On 1/7/26 at 10:15 AM, V12 (Licensed Practical Nurse) reviewed the electronic medical record and stated there was no documentation as to Hospice staff visit frequency, disciplines provided or instructions for cares. V12 stated the care plan identified R10 received Hospice services but lacked details of services provided and responsibilities for providers. V12 reviewed the Hospice binder and agreed there were no Hospice documents or communication notes included in the binder. V12 stated the Hospice nurse will usually ask for a verbal report prior to their visit but was unaware of the nurse visit frequency or other services being provided by the Hospice. On 1/7/26 at 10:20 AM, V13 (Certified Nursing Assistant) stated Hospice Aides do provide cares to R10 but was unaware of the days, time and/or frequency of the visits. On 1/7/26 at 1:15 PM, V11 (Hospice Registered Nurse) stated the facility updated the POLST (Physician's Order for Life Sustaining Treatment) although when the hospice received the new POLST, the form did not have the residents name on it, so it was sent back to the facility for correction. V11 stated the updated POLST had still not been received by the facility and was currently being addressed by the Hospice Physician. V11 stated prior to the residents visit, the Hospice nurse communicates with the facility's nurse to get a report of status. V11 stated there is a Hospice binder at the nurse's station but it does not have anything in it. Hospice staff does not document in the binder after visits. V11 stated he was R10's primary nurse and not attended or been involved in any care plan discussions or meetings with the facility. V11 receives Hospice skilled nurse visits, nurse aide visits, social worker and chaplain visits. On 1/9/26 at 9:55 AM, V1 (Administrator) agreed the facility failed to ensure that Hospice (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	communication was coordinated, and the required documents were available and accessible to the facility staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to perform hand hygiene between glove changes and failed to wear a gown when performing gastronomy tube flush for 3 (R3, R4 and R53) of 3 residents reviewed for infection control in a sample of 40.The facility policy titled, Glove Use-Nursing, last approved 10/2024, documents not in its entirety, Hand hygiene will be performed after removing gloves. When hands are not visibly dirty, alcohol-based hand sanitizers are the preferred method of cleaning your hands in the healthcare setting. Soap and water are recommended for cleaning visibly dirty hands. The facility policy titled, Hand Hygiene/Handwashing, last approved 10/2024, documents not in its entirety, Hand hygiene means cleansing your hands by using either handwashing (washing hands with soap and water), antiseptic hand wash, or antiseptic hand rub (i.e. alcohol-based hand sanitizer including foam or gel). Examples of when to perform hand hygiene (either alcohol based hand sanitizer or handwashing): Before glove placement, after glove removal. The facility policy titled, Enhanced Barrier Precautions, last approved 12/2025, documents not in its entirety, Statement of Purpose: Enhanced Barrier Precautions (EBP): recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. Personnel: Personnel providing direct care. Personal Protective Equipment: Gown and gloves. Policy: EBP may be considered and implemented for: Wounds and/or indwelling medical devices (central line, feeding tube, tracheostomy, drains, AV (arterial venous) fistulas, etc); Infection or colonization with a novel or targeted MDRO (Multidrug Resistant Organism) when contact isolation does not apply (see CDC/Center for Disease Control listed MDRO list); At discretion of the Infection preventionist. 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, wound care. 1. R3 was admitted on [DATE] with diagnoses of Osteomyelitis, Quadriplegia, Dysphagia, Cognitive Communication Deficit, Pressure Ulcers, Major Depressive Disorder, Neuromuscular Disfunction of Bladder and Suprapubic Catheter and Colostomy. On 1/7/26 at 11:00 AM, V3 (Infection Preventionist/Wound Nurse) changed gloves after cleansing the wound, then after packing the wound and again after completing the dressing change. No hand hygiene was conducted between glove change. On 1/9/25 at 9:55 AM, V1 (Administrator) agreed hand hygiene should have been conducted between glove change. 2. R4's admission Record documents R4's date of admission to the facility was 3/1/24 and his diagnoses include but not limited to Acute Respiratory Failure with Hypoxia, Encephalopathy, Dysphagia, Oropharyngeal, and Unspecified Protein-calorie Malnutrition. R4's Minimum Data Set (MDS) assessment dated [DATE], documents that R4 has a feeding tube. R4's current care plan documents R4 is on Enhanced Barrier Precautions related to: Feeding Tube. On 1/6/25 at 2:30 PM, V4 (Registered Nurse/RN) observed unhooking R4 from his enteral feeding and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	performing water flush. V4 (RN) performed hand hygiene, placed gloves, and filled a cylinder with water and with drew 100 milliliters of water into a syringe and proceeded to flush R4's gastronomy tube. V4 (RN) did not wear a gown through the entire procedure and when asked about what personal protective equipment should be worn, V4 (RN) stated, I was supposed to wear a gown with the gloves. On 1/6/25 at 2:35 PM, V3 (Infection Preventionist) stated, A resident with a G-Tube (Gastronomy Tube) would be on EBP (Enhanced Barrier Precautions), a gown and gloves are required to be worn by staff when doing any cares with the tube or any direct cares with the resident. The staff can also wear a face shield if they fill there is a potential for splashing to occur. V4 (Registered Nurse/RN) should have been wearing a gown because he was providing care. 3. R53's admission Record documents R53's date of admission to the facility was 9/16/25 and her diagnoses include but not limited to Cerebral Palsy, Type 2 Diabetes Mellitus without Complications and Dementia in other Diseases Classified Elsewhere, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. R53's physician orders dated 9/16/25 document R53 has an order for Accu-Check's QID (four times a day) before meals and at bedtime for diabetes and documents R53 has an order dated 11/11/25 for Humulin R (insulin) give 5 units subcutaneously before meals related to Type 2 Diabetes Mellitus without Complications. On 1/7/25 at 10:30 AM, V4 (RN) observed doing a medication pass. V4 (RN) parked medication cart across the hall, cleansed hands, placed on gloves and proceeded to R53's room to do blood sugar. V4 (RN) returned to the medication cart, removed soiled gloves, and placed clean gloves on without performing hand hygiene. On 1/7/25 at 10:40 AM, V2 (Director of Nursing) stated, Absolutely when asked if hand hygiene is to be performed between glove changes.