STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145886	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Aledo	304 S.W. 12th Street Aledo, IL 61231

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. 30899 Based on observations, interview and record review the facility failed to prevent resident to resident physical abuse for one resident (R2) of three residents reviewed for abuse in the sample of three. Findings include: Facility Policy/Abuse Prevention and Reporting dated 9/2024 documents: This facility prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. This assumes that all instances of abuse of residents, even those in a coma, cause physical harm or pain or mental anguish. The term willful in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical abuse includes, hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. Resident-to-Resident Abuse (any type): A resident-to-resident altercation should be reviewed as potential situation of abuse. Current Physician Order Summary Report indicates R1 was admitted to the facility Memory Care Unit on 6/24/2024 with diagnoses that include Dementia without Behavioral Disturbance, Vascular Dementia with Mood Disturbance, Mood Disorder, Generalized Anxiety Disorder. On 1/16/25 R1 and R2 were observed to reside in the locked Memory Care Unit within the facility. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Final Abuse Investigation Report indicates that on 11/29/24 R1 and R2 were involved in a resident-to-resident altercation. Report indicates R2 was talking to another resident when R1 approached and made contact with a closed hand to R2's left front shoulder. Report indicates R1 and R2 were separated by staff and assessed. Report indicates no visible injuries or psychosocial needs were noted at time of assessment. Report indicates R1 and R2 were interviewed and neither could recall the incident. Report indicates R1 scores a 5/15 on MDS/BIMS (Minimum Data Set/Brief Interview for Mental Status) and R2 scores a 3/15 on MDS/BIMS. Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated 10/1/24 documents: BIMS scores from (0 - 7) indicate severe cognitive impairment. On 1/16/25 at 2:40pm V6, CNA (Certified Nurse Assistant) stated (on 11/29/24) she looked up from charting and saw R1 hit R2 in the front shoulder area with a closed fist. V6 stated R1's hand did make contact with R2 but not so hard as to knock her backward. V6 stated R1 and R2 were separated and no further behaviors were observed. V6 stated R2 irritates other residents because she wanders all over, in/out resident rooms but R2 was just talking to another resident when R1 struck R2. Final Abuse Investigation Report indicates that on 12/02/2024 R2 was outside another resident's room when R1 approached R2 and contacted R2 with closed hands. Report indicates R2 then made contact to R1 with a closed hand, both residents were immediately separated by staff and assessed. No visible injuries or psychosocial needs noted at the time and both residents remained at their baseline. On 1/16/25 at 2:55pm V5, CNA stated (on 12/2/24) R2 was standing in the doorway of another residents room when she witnessed R1 hitting R2 with both fists along R2 front and back torso. V5 stated R2 tried to defend herself, striking back at R1 and grabbing a wet floor sign and hitting R1 on his backside as R1 was walking away.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 30899 Based on observation, interview and record review the facility failed to initiate interventions to prevent resident to resident abuse for one resident (R2) of three residents reviewed for abuse in the sample of three. Findings include: Facility Policy/Abuse Prevention and Reporting dated 9/2024 documents: The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by: Immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property; Implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making necessary changes to prevent future occurrences. Protection of Residents: The facility will take steps to prevent potential abuse while investigation is underway. Residents who abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. In addition, the facility shall take all steps necessary to ensure the safety of residents including, but not limited to, the separation of residents. Facility Policy/Behavioral Health Services program dated 2/2024 documents: When inappropriate or distressed behaviors occur, interventions should be implemented by utilizing the least restrictive or least intrusive measures first, and evaluating the effectiveness of those interventions before utilizing more restrictive interventions. Document all interventions attempted, including medication administered and the residents response to interventions as indicated. If the behavior symptoms do not subside or resolve, or if the resident exhibits behaviors that pose a threat to themselves or others, place the resident on 1:1, notify the physician and consulting services for psychiatric care for further orders or call 911 as deemed appropriate and notify family/resident representative of new interventions implemented (i.e. 1:1 monitoring, transfer to appropriate level of care). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Current Physician Order Summary Report indicates R1 was admitted to the facility Memory Care Unit on 6/24/2024 with diagnoses that include Dementia without Behavioral Disturbance, Vascular Dementia with Mood Disturbance, Mood Disorder, Generalized Anxiety Disorder. Current Physician Summary Report indicates R2 was admitted to the facility 7/2/24 with diagnoses that include Unspecified Dementia with Agitation and Major Depressive Disorder. On 1/16/25 R1 and R2 were both observed to reside in the locked Memory Care Unit within the facility. On 1/16/25 at 9:45am R2 was sitting in a common area where both the short and long halls of the unit meet talking with a female resident, R4. A few minutes later, R1 came walking up the long hall and walked passed R2 and R4 proceeding into the dining area. R2 did not seem to notice R1 and R1 did not seem to notice R2. At that time, V4, Agency LPN (Licensed Practical Nurse) stated I wasn't told anything about keeping (R1) and (R2) apart. I know (R1) is being transferred to another facility tomorrow and I know he was in the front (North Unit) for awhile, but I didn't know why. Final Abuse Investigation Report indicates that on 11/29/24 R1 and R2 were involved in a resident-to-resident altercation. Report indicates R2 was talking to another resident when R1 approached and made contact with a closed hand to R2's left front shoulder. Report indicates R1 and R2 were separated by staff and assessed. Report indicates no visible injuries or psychosocial needs were noted at time of assessment. Report indicates R1 and R2 were interviewed and neither could recall the incident. Report indicates R1 scores a 5/15 on MDS/BIMS (Minimum Data Set/Brief Interview for Mental Status) and R2 scores a 3/15 on MDS/BIMS. Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated 10/1/24 documents: BIMS scores from (0 - 7) indicate severe cognitive impairment. On 1/16/25 at 2:40pm V6, CNA (Certified Nurse Assistant) stated (on 11/29/24) she looked up from charting and saw R1 hit R2 in the front shoulder area with a closed fist. V6 stated R1's hand did make contact with R2 but not so hard as to knock her backward. V6 stated R1 and R2 were separated and no further behaviors were observed. V6 stated R2 irritates other residents because she wanders all over, in/out resident rooms but R2 was just talking to another resident when R1 struck R2. V6 stated I don't know about 1:1 for (R2). I heard about 15 minute checks. Final Abuse Investigation Report indicates that on 12/02/2024 R2 was outside another resident's room when R1 approached R2 and contacted R2 with closed hands. Report indicates R2 then made contact to R1 with a closed hand, both residents were immediately separated by staff and assessed. No visible injuries or psychosocial needs noted at the time and both residents remained at their baseline. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 at 2:55pm V5, CNA stated (on 12/2/24) R2 was standing in the doorway of another residents room when she witnessed R1 hitting R2 with both fists along R2 front and back torso. V5 stated R2 tried to defend herself, striking back at R1 and grabbing a wet floor sign and hitting R1 on his backside as R1 was walking away. V5 stated I think (R1) was on 15 minute checks for awhile. They would be on paper. We were just told to keep an eye on them. V5 stated R2 was moved to the short hall, but still wandered down the long hall where R1's room was located (R2's)constantly in and out of residents rooms. Nurse Note dated 12/2/24 at 6:30pm indicates the IDT (Interdisciplinary Team) met to review peer to peer altercation (R1 and R2). Note indicates Root cause: poor impulse control and cognitive deficit. Intervention: (R2) room was moved (to room on short hall). Nurse Note dated 12/29/24 at 1:21pm indicates R2 ambulating in hall entering other resident rooms. While attempting to redirect R2 to common areas and her room, R2 became agitated and resistant to care; difficult redirecting. Current Care Plan indicates R2 is at High Risk for Abuse/Neglect as noted from Abuse Screening score of 5. Care Plan intervention dated 12/2/24 indicates R2's room moved onto another wing. Care Plan indicates R2 has a behavior of wandering into other resident rooms (initiated 12/9/24). Current Care Plan does not address R2 being struck by R1 on 11/29/24 or 12/2/24 or identify any interventions to keep R2 safe from R1 except for changing R2's room which was not implemented until 12/2/24 after R2 was struck by R1 for the second time. Based on V6, CNA's statement on 1/16/24, the intervention of changing R2's room was not effective in keeping R2 from R1. No other interventions were addressed in R2's care plan. Incident Follow Up Note dated 12/03/24 at 9:51am indicates IDT met to review peer to peer altercation, R1 placed on 1:1 staff for 24 hours. 24 Hour Monitoring Log/15 Minute Resident Checks dated 12/2/24 indicates R2 was being monitored every 15 minutes from 2pm to 11:45pm on 12/2/24. 24 Hour Monitoring Log/15 Minute Resident Checks dated 12/3/24 indicates R2 was being monitored every 15 minutes from 12am to 3:30am; 5am to 4:15pm and from 5:45pm to 11:45pm on 12/3/24. Monitoring Log indicates 15 Minute Checks were initiated - not 1:1 monitoring. R2's Care Plan does not address 15 Minute Checks or 1:1 Monitoring/Supervision for any time period. Incident Note dated 12/19/24 at 12:05pm indicates Upon investigation it was noted that no one witnessed the incident take place. Note indicates two staff only heard R2 say Ow! and when staff responded (R1) was already down the hall, however R1 stated He pinched my ear. Note indicates R1 and R2 were separated. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SSD (Social Service Note) dated 12/19/24 at 3:54pm indicates Writer called (R1's Family) on 12/19/24 to provide information about a trial room move to North Hall. R1 moved to new room without incident. North Hall was not part of the Memory Care Secure Unit. R1's Care Plan indicates R1 has impaired cognitive function/dementia or impaired thought processes as evidenced by Dementia and Requires specialized unit for Dementia. On 1/17/25 at 11:25am V2, DON (Director of Nursing) stated it was a Corporate decision to move R1 off of the Memory Care unit. V2 stated R1 was not reassessed to see if he no longer needed a secure unit. They were just trying to keep R1 away from R2. V2 stated R1 almost immediately started trying to go out the exit doors and was increasingly agitated about being moved. V2 stated R1 had to go on 15 minute checks due to being an elopement risk on the un-secured unit he was moved to. Nursing Note dated 12/28/24 at 10:01am indicates R1 continues to exit out front door. Staff able to direct R1 back inside Ok to move (R1) back to (Memory Care Unit). Note indicates R1 was moved at that time. Care Plan does not indicate that any interventions were implemented to keep R1 away from R2 after R1's return to the Memory Care Unit on 12/28/24 through 1/17/25 when R1 was transferred out of the facility. On 1/17/25 at 11:15am V3, SSD (Social service Director) stated she was not aware at anytime that R1 was on actual 1:1 monitoring. V3 stated that would require additional staff and documentation. V3 stated if a resident requires 1:1 monitoring she should be notified. No interventions/protection was implemented from 11/29 to 12/2/24 The intervention implemented of moving R2 to another room on the Memory Care unit on 12/2/24 was ineffective in preventing interaction or protection of R2. One to One monitoring implemented for R1 on 12/2/24 to 12/3/24 was actually 15 Minute check monitoring for 24 hours. No other interventions/protections were in place from 12/4/24 to 12/19/24 when R1 again struck R2. R1 was then transferred to a non-secure unit on 12/19/24 which was unsuccessful as R1 was a known elopement risk and required R1 to be transferred back to the Secure Unit on 12/28/24. No interventions/protections were implemented after R1 returned to the unit R2 where R2 was still residing.