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	08/23/2025

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 - Some	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

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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 - Some	Based on interviews and record review, the facility failed to protect 3 residents (R2, R4, R6) from physical abuse by another resident, and failed to protect a resident from abuse by a staff member for 1 resident (R7). These failures apply to 4 of 7 residents reviewed for abuse in the sample of 7.The findings include: 1. Preliminary Abuse Investigation Report with incident date of 08/04/2025 documented at approximately 04:40 PM, shows R2 was allegedly involved in a physical altercation with a peer (R1). R2's interview form documented R2 was unable to recall any details related to incident. No final report was provided. R1's electronic face sheet printed on 08/23/2025 documented an admission date of 05/12/2025 with a past medical history not limited to dementia with behavioral disturbance, anxiety disorder, major depressive disorder, mood affective disorder, and hypertension. R1's Minimum Data Set (MDS) Section C for Cognitive Patterns provided on 08/23/2025 indicated that R1 has severe cognitive impairment, dated 07/15/2025.R1's care plan detail reads in part: is/has potential to be verbally aggressive (cursing at others) last revised 06/10/2025; has impaired cognitive function related to dementia diagnosis last revised 06/23/2025; is receiving anti-psychotic medications related to dementia with psychotic disturbance-paranoid thoughts, resisting cares, verbal outbursts, aggression toward others last revised 06/23/2025; is/has potential to be physically aggressive last revised 07/24/2025. R1's nursing note dated 08/04/2025 at 04:15 PM (16:15) documented that resident was standing with cane in his hand next to another resident (R2) who was sitting in a wheelchair yelling. Certified nursing assistant (CNA) stated resident got up from his chair and went to another resident and hit him across the nose with his cane. Residents were separated. Other resident was checked for injuries with none noted.On 08/23/2025 at 10:56 AM, observed R1 ambulating in dining room of dementia unit and attempted to interview R1 regarding the incident with R2. R1was alert to self and stated, I'm tired of talking to people, leave me alone. At 01:51 PM, observed R1 lying in bed and attempted to interview R1 at this time but R1 was not interviewable. R2's electronic face sheet printed on 08/23/2025 documented an admission date of 11/17/2022 with a past medical history not limited to: dementia, dysthymic disorder (persistent depressive disorder) and altered mental status.R2's Minimum Data Set (MDS) Section C for Cognitive Patterns provided on 08/23/2025 indicated that R2 has severe cognitive impairment, dated 07/18/2025. R2's care plan detail reads in part: has impaired cognitive function or impaired thought processes related to dementia as evidenced by repetitive verbalizations and wandering behavior last revised 06/10/2025; at a high risk for abuse/neglect as noted from abuse screening related to assessment score of 5, history of involvement in peer incidents, date initiated 08/05/2025.R2's abuse/neglect screen dated 08/04/2025 indicated that R2 is at high risk for abuse/neglect. R2's nursing note dated 08/04/2025 at 04:15 PM (16:15) documented, this nurse was charting when I heard someone yell out upon entering day room, resident was yelling. CNA stated another resident got up from his chair (R1) and walked over and hit this resident across the nose with his cane.On 08/23/2025 at 10:55 AM, observed R2 seated at table in same dining room and noted light purple bruising to R2's right outer eye area and a small laceration to R2's upper right eyelid. R2 was alert to self and was not interviewable. R2 did not recall any details related to the incident with R1. On 08/23/2025 at 11:05 AM, V3 (Licensed Practical Nurse) said on the day of incident between R1 and R2, she was in the nurse's office on the unit when she heard someone yell out. V3 said she went out into the day area and observed R2 in his wheelchair and saw R1 walking with his cane away from R2. V3 then indicated that V4 (Certified Nursing Assistant) witnessed the incident and informed V3 that R1 whacked R2 across the bridge of his nose with his cane. V3 added that both residents were seen by psych provider; R1 had a medication change that seems to be helping with his aggression. V3 also said that the injuries to R2's right eye were from another incident and not from incident with R2.On 08/23/2025 at 11:13 AM, V4 (CNA) said on day of the incident, she was coming up the short hall on unit when she saw R1 hit the top of R2's nose with his cane, then R2 yelled out ow. V4 added that R1 can be aggressive and uses his cane as a weapon and had hit other residents in the past with his cane. V4 added that R1's cane has since been taken away and R1 now uses a wheeled walker. V4 showed this surveyor R1's cane that was being stored in the nurse's office and indicated that padding was taped around the flat handle but R1 kept removing it. On 08/23/2025 at 04:01 PM, V1 (Administrator) said R1 was transitioned from his cane to a walker because he was using as his cane as a weapon. 2. Final abuse investigation report provided by facility on 08/23/2025 documented on 08/04/2025 at approximately 04:45 PM, V4 (CNA) was walking past R3's room when she observed R3 push R4. Residents were separated and assessed for injuries with no