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	11/12/2025

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. Based on record review and interview the facility failed to assess one resident (R1) of three reviewed for fall risk.R1 was admitted to the facility 12/28/23 with diagnoses to include, but not limited to: Major Depressive Disorder, Benign Prostatic Hyperplasia, Hypertension, Diabetes, and Cerebral Ischemia.R1 fell 10/28/25 at 5:05 AM resulting in R1 sustaining a right hip fracture.The facility's Fall Prevention Program policy dated 05/2025 documents, The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision. A Fall Risk Assessment will be performed at least quarterly and with each significant change in mental or functional condition and after any fall incident.R1's medical record does not document a fall risk assessment completed November 2024 through August 2025.On 11/7/25 at 1:28 PM, V1 (Director of Nursing) verified R1 did not have a fall risk assessment completed quarterly November 2024 through August 2025.On 11/12/25 at 12:32 PM V11 (Regional Registered Nurse) verified the facility policy documents a resident is to have a fall risk assessment completed on admission and quarterly and that R1 did not have a fall risk assessment completed November 2024 through August 2025.

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