

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care Aledo		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to maintain a resident's right to be treated with dignity for (R6), one of eight residents reviewed for resident rights, in a sample of 8. This failure resulted in R6 to suffer shame and embarrassment. The (State) Long-Term Care Ombudsman Program Residents' Rights for People In Long-Term care Facilities, provided to all new residents upon admission to the facility documents, As an individual living in a long-term care facility, you retain the same rights as every citizen of (State) and of the United States. The following regulations provide clarity on specific rights granted to residents living in long-term care facilities. Your rights to dignity and respect* Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. The facility Dignity policy, dated (effective) 03/2024 directs staff, The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Staff shall carry out activities in a manner which assists the resident to maintain and enhance his/her self-esteem and self-worth. Refrain from practices demeaning to residents such as refusing to comply with a resident's request for bathroom assistance during meal times. The facility Final Abuse Investigation Report dated Initial Report 9/19/25 and Final Report 9/24/25 documents, Staff (V6/Registered Nurse) to resident (R6) verbal altercation. On 9/19/2025 at approximately 9:30 P.M., V7/Licensed Practical Nurse observed R6 visibly upset, while V7 was doing medication pass. R6 reported to the nurse on shift (V7) that the previous shift nurse (V6/RN) would send a CNA (Certified Nursing Assistant) to put her on the bedpan. V6/RN immediately suspended. Investigation began. R6's (facility) handwritten statement, dated 9/23/2025 documents, Friday I was admitted in to (facility). I had fallen asleep and when I woke up it was 6:12 P.M., I hit my call light, (I) was in need of using 9the) bed pan. At 6:55 P.M., Head Nurse (V6/RN) came in and advised me that they had 5 residents that require(d) feeding assistance and once they are done, she has to over watch the dining area while 5 assisted (residents) are taken care of. Then she stopped and asked if I had gotten my food yet. I replied, 'no, but I desperately need to pee.' She (V6/RN) said, 'Oh fXXX, alright I'll send someone down.' At approximately 7:35 P.M. I was finally brought my supper. At approximately 8:15 P.M., I finagled myself to first reach (the) gray peanut looking bowl and managed to get it underneath of myself enough to use it as a bedpan. Estimated at 9:12 P.M., (V8 and V9/CNAs) came to check on me. I told them to be cautious cause on my dinner tray was the container I used to pee in and they said, hit your call light and we will help you. I informed them that (V6/RN) had 2 hours prior said she would send someone in to assist me and they both informed me that to their knowledge, (V6/RN) never once said a word to anyone about me needing to use the restroom. On 11/23/25 at 9:38 A.M., V7/Licensed Practical Nurse (LPN) stated she was the nurse working the evening of 9/19/25. V7/LPN states she was doing the evening medication pass and she heard R6 crying. V7 states when she entered R6's room, R6 was crying and very upset stating that earlier in the day, she had asked V6/Registered Nurse (RN) to assist her on the bedpan as she had to urinate. States V6/RN told R6 all staff were busy assisting other residents. R6 states V6 swore at R6 and told her she would get someone to help R6 when they could. V7/LPN states that R6 told her a couple of hours later, no staff (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
--	-------	-----------

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care Aledo		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Actual harm Residents Affected - Few	had responded to assist her on the bedpan and R6 was finally able to get herself closer to her bedside stand, grab an emesis basin, place it under herself and pee. V7 states R6 was very upset about having to use the emesis basin, that it hurt to use the emesis basin and not a bedpan and that R6 stated she was humiliated due to using the emesis basin to urinate in. At that time, V7/LPN states R6 told her she did not want V6/RN to ever take care of her again. On 11/25/25 at 1:05 P.M., V1/Administrator In Training stated V6/Registered Nurse should have assisted R6 to the toilet when she requested, and she considers R6 being forced to urinate in an emesis basin as unacceptable and a violation of R6's resident's rights.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care Aledo		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to recognize an altercation between an employee and a resident as verbal abuse, failed to prevent access to all other facility residents by the same employee, resulting in this employee verbally abusing a second resident (R7) on a different occasion, failed to prevent resident to resident physical abuse for three of three residents (R2, R3 and R5) and failed to prevent employee to resident physical abuse (R8), for eight of eight residents reviewed for abuse, in a sample of 8. This failure has the potential to affect all 51 facility residents and resulted in R6 to feel fear, anxiety and shame. These failures resulted in an Immediate Jeopardy. The Immediate Jeopardy started on 9/19/25 when V6/Former Employee Registered Nurse entered R6's room and verbally assaulted her within the facility. V2 (Director of Nursing) and V12 (Regional Nurse) were notified of the Immediate Jeopardy on 11/26/25 at 2:45 PM. While the immediacy was removed on 11/12/25, the facility remains out of compliance at a severity Level II as additional time is needed to evaluate the implementation and effectiveness of their removal plan and Quality Assurance monitoring. The facility Abuse Prevention and Reporting policy, dated 09/2024 directs staff, 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. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. 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 also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain and/or maintain physical, mental and psychosocial well-being. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means. Physical abuse includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment. Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation. Verbal abuse includes the use of oral, written or gestured communication, or sounds, to residents within hearing distance. A resident-to-resident altercation should be reviewed as 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. The facility Preliminary Abuse Investigation Report dated 9/19/25 documents, Verbal or Mental Abuse. On 09/19/2025 at approximately 9:15 P.M., (R6) reported alleged verbal altercation with an employee (V6/Registered Nurse). (V6/RN) suspended immediately. Appropriate notifications made. Investigation initiated. 5-day Final (Report) to come. The facility Final Abuse Investigation Report dated 9/24/25 documents, On 09/19/25 at approximately 9:30 P.M., V7/Licensed Practical Nurse (LPN) observed R6 visibly upset while she was doing (a) med (medication) pass. R6 reported to V7 that the previous shift nurse (V6/RN) would send a CNA (Certified Nursing Assistant) to put her on bedpan. Staff provided peri care to (R6). R6 was assessed for any psychosocial injuries. No psychosocial needs noted. Facility leadership reviewed the medical record of (R6). Employees who were knowledgeable of the allegation were interviewed by the Abuse Coordinator. Based on the results of the investigation the facility has found the following: IDT (Intradisciplinary Team) met to discuss the investigation. Also discussed appropriate interventions for (R6). Care plan reviewed and updated accordingly. SSD (Social Services Director) will follow up with resident for any psychosocial needs that arise. The facility form, Statement of (R6), dated 9/23/25 and signed by R6 documents, Friday (9/19/25) I was admitted in to (facility). I had fallen asleep and when I woke up it was 6:15 PM. I hit my call light, (I) was in need of (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care Aledo		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Immediate jeopardy to resident health or safety Residents Affected - Some	using (the) bedpan. At 6:55 PM, Head Nurse (V6/RN) came in and advised me that they have 5 residents that require feeding assistance and once they are done, (V6) has to watch over the dining area while 5 assisted (residents) were taken care of. The (V6) stopped and asked if I had gotten my food yet. I replied no, but I desperately need to pee, (V6) said, 'Oh fuck, alright. I'll send someone down.' At approximately 7:35 P.M. I was finally brought my supper. At approximately 8:15 PM, I finagled myself to first reach the gray peanut looking bowl (emesis basin) and managed to get it underneath of myself enough to use it as a bed pan. Estimated around 9:12 PM. (V9 and V8/Certified Nursing Assistants) came to check on me. I told them to be cautious cause on my dinner tray was the container I used to pee in. They said, 'Hit your call light we will help you.' I informed them (V6/RN) had two hours prior said she would send someone in to assist me and they both informed me that to their knowledge, (V6/RN) never once said a word about me needing to use the restroom. The facility form, Staff Statement, dated 9/19/23 and signed by V9/CNA documents, We (myself and V8/CNA) went into (R6's) room around 9:15 P.M. to meet the new resident (R6). (R6) was very unhappy due to asking (V6/RN) around 6:15 P.M. to go to the restroom. (R6) said (V6) told her she would get someone. I was never informed and did not know we had a new resident (R6) until entering (R6's) room. (R6) wanted to call her family. We explained we had no cordless (phone). We did let (R6) use our (phone). We asked if (R6) needed anything else and apologized to (R6). (R6) did urinate in a mouth wash basin due to not being put on a bedpan when asked. The facility form, Staff Statement, dated 9/19/25 and signed by V8/CNA documents, After supper, (V9/CNA) and I went to answer call lights. We went down to (R6's) room to see what she wanted. We were informed that she had her call light on, to use the restroom from 6:15 PM to 7:30 PM. (R6) told us (V6/RN) was informed and that (V6) would come tell us. We never got informed and (R6) had to use a small basin so she didn't pee her pants. Later on (R6) was upset and wanted to call her mother. (R6) told us that (V6/RN) told her to stop turning on her light. The facility form, Staff Statement, dated 9/19/25 and signed by V7/Licensed Practical Nurse (LPN) documents, During med (medication) pass I overheard (R6) crying to (V8 and V9/CNAs). Upon entering (R6's) room, R6 stated she called her parents, and they were coming to get her, (R6) wasn't going to stay here (facility). (R6) was very upset and stated the nurse wearing a red shirt (V6/RN) answered her call light and told her not to put it on again, that the staff were busy, and she had already put it on three times, in an hour. (R6) stated (V6) was very rude and yelled at her. (R6) told (V6) she needed the bedpan. (V6) stated she will tell someone. (R6) waited two hours before someone came back to help her. The untitled facility form dated 9/25/25 and signed by V1/Administrator in Training documents, On 9/24/25, myself, (V14/Corporate Human Resources Director) and V2/Director of Nurses spoke with (V6/RN) about the incident that was reported on 9/19/25. (V6/RN) stated she asked one of the CNAs (Certified Nursing Assistants) to put (R6) on the bedpan. When asked what VNA she asked, (V6) stated, 'I thought I told (V8). (V8) was asked if (V6) asked her to put (R6) on the bedpan, (V8) stated that ((V6) did not ask her. (V9), the second CNA working on the evening of 9/19/25, also stated that (V6) never asked her to put (R6) on the bedpan. When (V6) was asked if she were carrying out a task that would prevent her from assisting (R6), she stated the hospital reported that (R6) was a 2 (person) assist. Upon investigating, it was found that (R6) was not a 2 person assist for bed mobility. R6's facility admission Record documents that R6 was admitted to the facility on [DATE], from a local hospital with the following diagnoses Major Depressive Disorder, Acute Pain in Left Hip and Iron Deficiency Anemia. R6's facility admission assessment dated [DATE] documents that R6 is alert and oriented to person, place, time and situation. R6's Nursing Progress Notes, dated 9/19/25 documents that R6 was admitted to the facility on [DATE] at 4:05 P.M. On 11/23/25 at 9:38 A.M., V7/Licensed Practical Nurse (LPN) stated she was the nurse working the evening of 9/19/25. States she was doing the evening medication pass and she heard R6 crying. States when she entered R6's room, R6 was crying and very upset stating that earlier in the day, she had asked V6/RN to assist her on the bedpan as she had to urinate and V6 refused to assist her. States R6 said the incident occurred around 6 PM. States V6 told R6 all staff (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care Aledo		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Immediate jeopardy to resident health or safety Residents Affected - Some	were busy assisting other residents. R6 states V6 swore at (R6) and told her she would get someone to help R6 when they could. V7 states that R6 told her a couple of hours later, no staff had responded to assist her on the bedpan and R6 was finally able to get herself closer to her bedside stand, grab an emesis basin, place it under herself and pee. V7 states R6 was very upset about having to use the emesis basin, that it hurt to use the emesis basin and not a bedpan and that R6 stated she was humiliated due to using the emesis basin to urinate in. At that time, V7 states R6 told her she did not want V6 to ever take care of her again. On 11/25/25 at 11:54 A.M., V2/Director of Nurses (DON) stated she would consider verbal abuse to include anything that an employee would say to a resident that would upset the resident or hurt their feelings, name calling or vulgar language. States she and the facility administrator (V1) were the ones that investigated the 9/19/25 occurrence between V6/Registered Nurse and R6. V2/DON states she would consider staff cursing at, or in front of a resident, as verbal abuse. States V6 was given a 3-day suspension after the 9/19/25 incident and reprimanded for ?Misconduct- Failure to Meet Resident Needs. States V6 returned to work on 10/1/25 and the delay was caused by a delay in investigating the 9/19/25 incident. V2 states she did not make the decision to call the incident misconduct, nor did she make the decision to recommend a 3-day suspension. V2 states V12/Regional Nurse Consultant, V13/Regional Director of Operations and V14/Corporate Human Resources Director made the decision. V2 states V6/RN then worked throughout the facility for the rest of September, all of October and into November 2025. On 11/25/25 at 1:05 P.M., V1/Administrator stated she would consider verbal abuse as derogatory comments directed towards a resident, cursing in front of, or at a resident, yelling, harassing, etc. States she and V2/DON investigated the 9/19/25 incident between V6/RN and R6. States R6 had just been admitted to the facility that afternoon. States R6 was alert and oriented and wrote her own statement to the incident. States R6 was upset about the incident and stated R6 told her V6 came into her room, cussed at her, refused to offer her toileting assistance and R6 was forced to urinate in an emesis basin, as a bed pan was not provided for her. V1 states after gathering a statement from R6 and V7/LPN and V8 and V9/CNAs, she contacted corporate staff (V12/Regional Nurse Consultant, V13/Regional Director of Operations and V14/Corporate Human Resources Director) and the decision was made to suspend V6 for 3 days and call the incident ?Misconduct.' V1 confirms R6 was informed of the decision and returned to work on 10/1/25. V1 confirms the facility Employee Handbook, which was reviewed and provided to V6 in December 2024 documents that, 'Engaging in abusive, discourteous, profane, indecent or unprofessional language or conduct while on duty or on (facility) property is grounds for immediate dismissal. A review of V6/Registered Nurse's facility Timecards documents that V6 continued to work at the facility from 9/19/25 through 11/12/25. 2. The facility form, Final Abuse Investigation Report, dated (initial) 11/13/25 and (final) 11/19/25 documents, Resident: (R7) and Staff: (V6/Registered Nurse-RN). Staff to resident verbal altercation. Facts determined: On 11/12/25 at approximately 7:40 A.M., R7 told V6/RN that he needed to use the restroom. V6/RN asked R7 if he could wait due to staff being busy and her having to stay in the dining room. R7 stated that he needed to go, and he was not waiting. V6/RN took R7 down the hallway where the CNAs (Certified Nursing Assistants) were assisting another resident. V6 returned to the dining room. No psychosocial needs noted. Proper notifications made. V6/RN suspended immediately. Abuse Coordinator immediately initiated investigation. Facility leadership reviewed the medical record of R7. Employees who were knowledgeable of the allegation were interviewed by the Abuse Coordinator. Based on the results of the investigation the facility has found the following: IDT (Intradisciplinary Team) met to discuss the investigation. Also discussed appropriate interventions for resident. Care plan reviewed and updated accordingly. SSD (Social Services Director) will follow up with resident for any psychosocial needs that arise. R7's Abuse Allegation Interview, dated as 11/12/25 and signed by V1/Administrator in Training documents, Can you tell me what happened? I needed to pee. so, I didn't wet myself. (V6/RN) yelled at me and pushed me in my wheelchair down the hall. What was said? (V6/RN) was cussing and saying I already went. The facility form, Staff (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care Aledo		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Statement, dated 11/12/25 and signed by V8/Certified Nursing Assistant/CNA documents, I was in (another resident's room) with (V9/CNA). V6/RN was shouting at (R7) because he needed to use the bathroom. V6 then pushed R7 down the long hall and said, 'See all these call lights' and told R7 he needed to wait and let R7 down the hall. During V6's shouting, V6 mentioned the F word, saying, 'Fuck this' and 'You need to fucking wait.' The facility form, Staff Statement, dated 11/12/25 and signed by V9/Certified Nursing Assistant/CNA documents, (V6/RN) brought (R7) to the end of the hallway and says, '(R7) needs to be taken to the fucking bathroom now.' R7's current Minimum Data Set Assessment, dated 11/13/25 documents R7's BIMS (Brief Interview for Mental Status) as 8:15 (moderate cognitive impairment) and his toileting assistance as frequently incontinent and dependent on staff for toileting. On 11/23/25 at 1:05 P.M., R7 was alert and sitting at the side of his bed. R7 was unable to recall V6's name but did recall an incident with a nurse that occurred recently where he requested to use the restroom, when he was sitting in the dining room waiting for his breakfast. R7 states he needed to pee, so he didn't wet himself. Stated the nurse told him all staff were busy, and he would have to wait. Stated the same nurse cussed at him, pushed his wheelchair out into the hall and left him sitting in the hallway. States he did not hear the nurse ask any staff to assist him and when the CNAs did assist him, he had urinated on himself. States he was humiliated by the situation and doesn't want (V6/RN) to come near him any longer. On 11/23/25 at 1:25 P.M., V9/Certified Nursing Assistant (CNA) stated she was working the day of the incident with V6/Registered Nurse (RN) and R7. V9/CNA states she was in another resident's room when she heard V6/RN yelling and swearing at R7. V9/CNA states V6/RN entered the resident room where she was assisting another resident and V6/RN yelled that R7 needed to be taken to the fucking bathroom. V9/Certified Nursing Assistant stated when she and V8/Certified Nursing Assistant (CNA) were able to take R7 to the bathroom, he had been incontinent in his pants and expressed he was humiliated by the situation. On 11/24/25 at 11:13 A.M., V8/Certified Nursing Assistant (CNA) stated she was working the day of the incident involving V6/Registered Nurse (RN) and R7. V8/CNA stated she and V9/Certified Nursing Assistant (CNA) were providing care to another resident when they heard V6/RN yelling and cussing at R7 because (R7) needed to use the bathroom, from the hallway. V8/CNA stated V6 was yelling at R7, 'See all these call lights (on), and yelling at (R7), 'you need to fucking wait to use the bathroom.' Then V6/RN left R7 sitting in the hallway, outside of the room where we were helping someone else. V8/CNA states when she and V9 were able to get to R7 he had urinated on himself and was very upset about it. On 11/25/25 at 11:54 A, M, V2/Director of Nurses stated the 11/12/25 incident between V6/RN and R7 was also investigated by herself and V1/Administrator. V2/DON states she would consider the incident to be verbal abuse as the resident and two different staff members overheard V6/RN cussing and yelling at R7 V2 states V12, V13 and V14 (Corporate Staff) made the decision to call the incident Misconduct: Unsatisfactory job performance and place V6 on a 'Final Warning.' V2 states when she and V1 called R6 to discuss the incident and advise her of the final warning and tell V6 to return to work on November 21, 2025, V6 stated she was terminating her employment with the facility. On 11/25/25 at 1:05 P.M., V1/Administrator in Training stated there was a second incident on 11/12/25 involving V6/Registered Nurse and R7 where V6 was overheard cussing and yelling at R7 when R7 requested to use the bathroom while in the facility dining room as he didn't want to urinate on himself. V1 states during her investigation it was determined that V6 refused to provide toileting assistance for R7, pushed R7's wheelchair out of the dining room and down the hall, opposite direction from his room and placed him outside of another resident's room where V8 and V9/CNAs were providing care to another resident. V1 stated the incident was discussed with corporate staff (V12, V13 and V14) and the decision was made, at the corporate level, to call the incident, 'Misconduct' and to place V6/RN on a final warning. When V6 was called on 11/20/25 and informed of the decision to place her on a final warning status and to inform V6 to return to work on 11/21/25, V6 chose to terminate her employment with the facility.3. The facility form, Final Abuse Investigation report, dated (initial) 9/1/25 and (final) 9/5/25 documents, Resident (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care Aledo		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Immediate jeopardy to resident health or safety Residents Affected - Some	to resident physical abuse. On 9/1/25 at 12:35 P.M., R1 was propelling out of the dining room. R2 was in a wheelchair adjacent to dining room entrance. CNA (Certified Nursing Assistant/V3) heard yelling, went to investigate and observed R2 make physical contact with R1. CNA and Nurse immediately separated both residents. (V17/Licensed Practical Nurse) assessed both residents. proper notifications made. On 11/23/25 at 9:51 A.M., V3/Certified Nursing Assistant (CNA) stated she was working on 9/1/25 when she witnessed R1 propelling himself out of the locked unit dining room while R2 was entering the dining room. V3/CNA states R2 began yelling at R1 and cussing at R1 and when their wheelchairs came into contact, R2 stood up and hit R1 in the face. 4. The facility form, Final Abuse Investigation report, dated (initial) 9/18/25 and (final) 9/23/25 documents, Resident to resident physical abuse. On 9/28/25 at approximately 8:05 A.M., R3 discovered R4 in his room. R3 stated he threw his coffee at R4. R4 stated that the coffee did not hit him. V4/Licensed Practical Nurse heard yelling in the hallway. proper notifications made. Investigation initiated. R3 Nursing Progress Note dated 9/23/25 documents, (R3) in hallway yelling at (R4). (R3) upset for (R4) I being in (R3's) room taking things. (R3) kicked and punched (R4) in head. Residents separated and taken back to rooms. Also reported to this nurse right before this incident (R3) threw coffee at (R4) and hit (R4). No injuries noted. MD (Medical Doctor) notified, and message left for (Power of Attorney).On 11/23/25 at 10:30 A.M., R3 was alert, and up in his room. R3 was able to recall the incident of 9/18/25. States R4 came into to his room and had his wheelchair back to R3. States he yelled at R4 to leave his room, R4 didn't move, so he kicked the back of R4'd wheelchair and threw his coffee on R4. At the same time, he was yelling for a nurse, who responded and removed R4 from his room.5. The facility form, Final Abuse Investigation report, dated (initial) 9/19/25 and (final) 9/26/25 documents, Resident to resident physical abuse. On 9/20/25 at approximately 7:00 P.M., Certified Nursing Assistant (CNA) V5 was helping another resident when she heard yelling coming from (R5's) room. R1 was in R5's room. V5/CNA observed R5 strike R1 with an open hand in the back of the head. CNA separated residents immediately and re-directed R1 out of R5's room. Proper notifications made.R5's Nursing Progress Notes, dated 9/20/25 document, Notified by (facility) staff nurse that physical altercation between (R1 and R5) took place. Staff nurse states (R1) wandered into (R5's) room and while R1 was in room, R5 states he asked (R1) numerous times to get out. R5 states he struck R1 in the back of the head with an open hand. R5 states V5/CNA entered the room at the same time he hit R1.6. The facility form, Preliminary Abuse Investigation Report, dated 11/23/25 documents, Physical Abuse, employee to resident. On 11/23/25 at approximately 5:30 P.M., R8 reported that agency staff (V10/Certified Nursing Assistant/CNA) was rough with cares. V10/CNA immediately suspended. R8 assessed immediately. Appropriate notifications made.On 11/24/25 at 11:17 A.M., R8 was alert, oriented, and seated in an easy chair in her room, reading her bible. R8 was able to recall the incident of 11/23/25. R8 states the tall, black man that took care of me yesterday (11/23/25) was rough with me and hurt my wrist during cares. States she was sitting in her chair in her room, reading her bible when V10/Agency CNA entered the room, roughly took her bible out of her lap and grabbed her right wrist and pulled on it, telling her she was wet (incontinent) and needed to get up and go to the bathroom. R8 states she told V10 she would as soon as she finished the passage she was reading, but V10 was insistent and kept pulling on her wrist. R8 states she told V10 he hurt her and to leave her alone. R8 states her wrist feels okay now but was painful yesterday.The facility form, Staff Statement, dated 11/23/25 and signed by V11/Certified Nursing Assistant documents, While in the dining room passing medications this nurse overheard (R8) telling her table (mates) at supper that the male CNA hurt her wrist. As I approached (R8) she stated that she did not want that male CNA take care of her again, he hurt her wrist. (R8) states (V10) came in her room, grabbed her bible out of her hands and told her to get up and go to the bathroom and he grabbed her wrist and hurt it. No injuries noted. V2/Director of Nurses and V1/Administrator notified. On 12/1/25 the surveyor confirmed through interview and record review that the facility took the following actions to remove the Immediate Jeopardy:1. All residents with a BIMS 12 and greater currently in-house had abuse (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care Aledo		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Immediate jeopardy to resident health or safety Residents Affected - Some	interview completed to ensure no other residents had been harmed and they feel safe in the facility completed by V24/Dietary Manager by 11/26/25.2. All residents with a BIMS 11 and below and skin assessments completed to ensure no other residents had been harmed and they feel safe in the facility completed by V2/Director of Nurses and V17/Wound Nurse by 11/26/25.3. Family members/POAs of those residents with a BIMS of 11 and below currently in-house had abuse interviews completed to ensure no other residents had been harmed and they feel that their loved one is safe in the facility. Initiated by V22/Business Office Manager on 11.26.25. 38 of these families answered the phone and were interviewed. A message to return the phone call has been completed with the remaining 13 families. Facility will continue to make daily calls until 100% compliance. Administrator to monitor for compliance. 4. All residents currently in-house had an abuse/neglect screening completed with care plans updated to reflect level of at risk for abuse as indicated. Completed by V23/Social Services Director on 11/26/25.5. Abuse in-servicing for all staff. Completed by V1/Administrator in Training and V2/Director of Nursing, on 11.26.25. Abuse Training will remain ongoing with all new hires, all agency staff, and current staff. All staff in serviced before their next scheduled shift. 6. Facility Administrator or Designee will interview 5 residents per week for 12 weeks to ensure residents feel safe and have no concerns with abuse. Facility will utilize the abuse Allegation Interview questions for residents. Completed on 11/26/25 by V1/Administrator in Training.7. Facility Administrator or Designee will interview 5 staff members per week x 12 weeks to ensure staff know reporting requirements. Facility will utilize an audit tool related to Abuse/Abuse Reporting/Abuse investigation. Facility Administrator or designee will monitor for completion. Completed by V1/Administrator in Training on 11/26/25.8. Administrator In Training in-serviced on abuse by V12/Regional Nursing Consultant on 11/26/25.9. All residents have the potential to be affected by V6(RN) alleged abuse. V6 (RN) is no longer employed as of 11/12/25.10. R6 had the potential to be affected by V6 (RN) alleged abuse. R6 discharged on 10/8/25. Psych services are available to all residents by Psychiatric vendor. Completion date 11/26/25		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care Aledo		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0607 Level of Harm - Actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to implement written policies and procedures for the investigation of allegations of abuse, including identification of abuse, failed in the protection of residents during investigations, and failed taking corrective actions for allegations of abuse, for two of eight residents reviewed for abuse (R6 and R7), in a sample of 8. These failures resulted in this same employee verbally abusing a second resident (R8) on a different occasion. The facility Abuse Prevention and Reporting policy, dated 09/2024 directs staff, 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. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. This will be done by Identifying occurrences and patterns of potential mistreatment; Immediately protecting residents involved in identified reports of possible abuse; and making necessary changes to prevent future occurrences. The facility Preliminary Abuse Investigation Report, dated 9/19/25 documents, Verbal or Mental Abuse. On 09/19/2025 at approximately 9:15 P.M., (R6) reported alleged verbal altercation with an employee (V6/Registered Nurse). (V6/RN) suspended immediately. Appropriate notifications made. Investigation initiated. 5 day Final (Report) to come. On 9:38 A.M., V7/Licensed Practical Nurse stated she was the nurse working the evening of 9/19/25. States she was doing the evening medication pass and she heard R6 crying. States when she entered R6's room, R6 was very upset stating that earlier in the day, she had asked V6/Registered Nurse (RN) to assist her on the bedpan as she had to urinate. States V6 told R6 all staff were busy assisting other residents. R6 states V6 swore (cussed) at R6 and told her she would get someone to help R6 when they could. At that time, V7 states R6 told her she did not want V6 to ever take care of her again. On 11/25/25 at 11:54 A.M., V2/Director of Nurses (DON) stated she and the facility administrator (V1) were the ones that investigated the 9/19/25 occurrence between V6/Registered Nurse and R6. V2/DON states she would consider staff cursing at, or in front of a resident, as verbal abuse. States V6 was given a 3-day suspension after the 9/19/25 incident and reprimanded for ?Misconduct- Failure to Meet Resident Needs. States V6 returned to work on 10/1/25 and the delay was caused by a delay in investigating the 9/19/25 incident. V2 states she did not make the decision to call the incident misconduct, nor did she make the decision to recommend a 3-day suspension. V2 states V12/Regional Nurse Consultant, V13/Regional Director of Operations and V14/Corporate Human Resources Director made the decision. V2 states V6/RN then worked throughout the facility for the rest of September, all of October and into November 2025. On 11/25/25 at 1:05 P.M., V1/Administrator stated she and V2/Director Of Nurses investigated the 9/19/25 incident between V6/Registered Nurse and R6. States R6 was upset about the incident and stated R6 told her (V6/Registered Nurse) came into her room, cussed at her, refused to offer her toileting assistance and R6 was forced to urinate in an emesis basin, as a bed pan was not provided for her. V1 states after gathering a statement from R6 and V7/LPN and V8 and V9/CNAs, she contacted corporate staff (V12/Regional Nurse Consultant, V13/Regional Director of Operations and V14/Corporate Human Resources Director) and the decision was made to suspend V6 for 3 days and call the incident ?Misconduct.' V1 confirms R6 was informed of the decision and returned to work on 10/1/25. V1 confirms the facility Employee Handbook, which was reviewed and provided to V6 in December 2024 documents that, 'Engaging in abusive, discourteous, profane, indecent or unprofessional language or conduct while on duty or on (facility) property is grounds for immediate dismissal. V1/Administrator also stated she would consider the incident to be verbal abuse, that V6/RN continued to work throughout the facility for the next two months and no changes were made to prevent future occurrences of abuse. A review of V6/Registered Nurse's facility Time Cards documents that V6 continued to work at the facility from 9/19/25 through 11/12/25. 2. The facility form, Final Abuse Investigation Report, dated (initial) 11/13/25 and (final) 11/19/25 documents, Resident: (R7) and Staff: (V6/Registered Nurse-RN). Staff to resident verbal (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care Aledo		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0607 Level of Harm - Actual harm Residents Affected - Few	altercation. Facts determined: On 11/12/25 at approximately 7:40 A.M., R7 told V6/RN that he needed to use the restroom. V6/RN asked R7 if he could wait due to staff being busy and her having to stay in the dining room. R7 stated that he needed to go and he was not waiting. V6/RN took R7 down the hallway where the CNAs (Certified Nursing Assistants) were assisting another resident. V6 returned to the dining room. No psychosocial needs noted. Proper notifications made. V6/RN suspended immediately. Abuse Coordinator immediately initiated investigation. Facility leadership reviewed the medical record of R7. Employees who were knowledgeable of the allegation were interviewed by the Abuse Coordinator. Based on the results of the investigation the facility has found the following: IDT (Intradisciplinary Team) met to discuss the investigation. Also discussed appropriate interventions for resident. Care plan reviewed and updated accordingly. SSD (Social Services Director) will follow up with resident for any psychosocial needs that arise. R7's Abuse Allegation Interview, dated as 11/12/25 and signed by V1/Administrator In Training documents, Can you tell me what happened? I needed to pee. so I didn't wet myself. (V6/RN) yelled at me and pushed me in my wheelchair down the hall. What was said? (V6/RN) was cussing and saying I already went. The facility form, Staff Statement, dated 11/12/25 and signed by V8/Certified Nursing Assistant/CNA documents, I was in (another resident's room) with (V9/CNA). V6/RN was shouting at (R7) because he needed to use the bathroom. V6 then pushed R7 down the long hall and said, 'See all these call lights' and told R7 he needed to wait and let R7 down the hall. During V6's shouting, V6 mentioned the F word, saying, 'FXXX this' and 'You need to FXXX wait.' On 11/25/25 at 11:54 A.M, V2/Director of Nurses stated the 11/12/25 incident between V6/RN and R7 was also investigated by herself and V1/Administrator. V2/DON states she would consider the incident to be verbal abuse as the resident and two different staff members overheard V6/RN cussing and yelling at R7 V2 states V12, V13 and V14 (Corporate Staff) made the decision to call the incident Misconduct: Unsatisfactory job performance and place V6 on a ?Final Warning.' V2 states when she and V1 called R6 to discuss the incident and advise her of the final warning and tell V6 to return to work on November 21, 2025, V6 stated she was terminating her employment with the facility. On 11/25/25 at 1:05 P.M., V1/Administrator In Training stated there was a second incident on 11/12/25 involving V6/Registered Nurse and R7 where V6 was overheard cussing and yelling at R7 when R7 requested to use the bathroom while in the facility dining room as he didn't want to urinate on himself. V1 states during her investigation it was determined that V6 refused to provide toileting assistance for R7, pushed R7's wheelchair out of the dining room and down the hall, opposite direction from his room and placed him outside of another resident's room where V8 and V9/CNAs were providing care to another resident. V1 stated the incident was discussed with corporate staff (V12, V13 and V14) and the decision was made, at the Corporate level, to call the incident, ?Misconduct' and to place V6/RN on a final warning. When V6 was called on 11/20/25 and informed of the decision to place her on a final warning status and to inform V6 to return to work on 11/21/25, V6 chose to terminate her employment with the facility. V1/Administrator also stated she would consider the incident to be verbal abuse, and no changes were made to prevent future occurrences of abuse.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care Aledo		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff refused to provide toileting assistance to two of two residents (R6 and R7), reviewed for Activities of Daily Living assistance, in a sample of 8. R6's Assessment Progress Note, dated 9/19/25 documents, 9/19/25 admitted from local hospital with diagnoses of Major Depressive Disorder and Acute Pain. R6's Nursing admission Assessment, dated 9/19/25, documents R6 as, Alert, oriented to person, place, time. Toileting assistance as requiring substantial/maximal assistance. R6's (facility) handwritten statement, dated 9/23/2025 documents, Friday I was admitted in to (facility). I had fallen asleep and when I woke up it was 6:12 P.M., I hit my call light, (I) was in need of using (the) bed pan. At 6:55 P.M., Head Nurse (V6/RN) came in and advised me that they had 5 residents that require(d) feeding assistance and once they are done, she has to over watch the dining area while 5 assisted (residents) are taken care of. Then she stopped and asked if I had gotten my food yet. I replied, 'no, but I desperately need to pee.' She (V6/RN) said, 'Oh fXXX, alright I'll send someone down.' At approximately 7:35 P.M. I was finally brought my supper. At approximately 8:15 P.M., I finagled myself to first reach (the) gray peanut looking bowl and managed to get it underneath of myself enough to use it as a bedpan. Estimated at 9:12 P.M., (V8 and V9/CNAs) came to check on me. I told them to be cautious cause on my dinner tray was the container I used to pee in and they said, hit your call light and we will help you. I informed them that (V6/RN) had 2 hours prior said she would send someone in to assist me and they both informed me that to their knowledge, (V6/RN) never once said a word to anyone about me needing to use the restroom. On 11/23/25 at 9:38 A.M., V7/Licensed Practical Nurse (LPN) stated she was the nurse working the evening of 9/19/25. V7/LPN states she was doing the evening medication pass and she heard R6 crying. V7 states when she entered R6's room, R6 was crying and very upset stating that earlier in the day, she had asked V6/Registered Nurse (RN) to assist her on the bedpan as she had to urinate. States V6/RN told R6 all staff were busy assisting other residents. R6 states V6 swore at R6 and told her she would get someone to help R6 when they could. V7/LPN states that R6 told her a couple of hours later, no staff had responded to assist her on the bedpan. On 11/25/25 at 1:05 P.M., V1/Administrator In Training confirmed V6/Registered Nurse should have assisted R6 to the toilet when she requested. 2. R7's facility admission Record documents that R7 was admitted to the facility on [DATE] with the following diagnoses Cerebral Ischemia, Type 2 Diabetes Mellitus and Fractured Femur (10/31/25). R7's most recent Minimum Data Set Assessment, dated 11/23/25 documents R7's Cognitive Status as 8:15 (moderately impaired) and his Toileting Assistance Needed as frequently incontinent and dependent on staff for assistance. R7's current Care Plan includes the following Focus Area: (R7) has an ADL (Activities of Daily Living) performance deficit. Also included are the following Interventions: Toilet Use- (R7) is dependent upon staff for toileting. The facility form, Final Abuse Investigation Report, dated (final) 11/19/25 documents, On 11/12/25 at approximately 7:40 A.M., R7 told V6/Registered Nurse (RN) that he needed to use the restroom. V6/RN asked R7 if he could wait due to staff being busy and her having to stay in the dining room. R7 stated that he needed to go and he was not waiting. V6/RN took R7 down the hallway where the CNAs (Certified Nursing Assistants) were assisting another resident. V6 returned to the dining room. On 11/23/25 at 1:05 P.M., R7 was alert and sitting at the side of his bed. R7 was unable to recall V6's name but did recall an incident with a nurse that occurred recently where he requested to use the restroom, when he was sitting in the dining room waiting for his breakfast. R7 states he needed to pee, so he didn't wet himself. Stated the nurse told him all staff were busy, and he would have to wait. Stated the same nurse cussed at him, pushed his wheelchair out into the hall and left him sitting in the hallway. States he did not hear the nurse ask any staff to assist him and when the CNAs did assist him, he had urinated on himself. States he was humiliated by the situation and doesn't want (V6/RN) to come near him any longer. On 11/25/25 at 1:05 P.M., V1/Administrator In Training stated there was a second incident on 11/12/25 (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care Aledo		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	involving V6/Registered Nurse and R7 when R7 requested to use the bathroom while in the facility dining room as he didn't want to urinate on himself. V1 states during her investigation it was determined that V6 refused to provide toileting assistance for R7, pushed R7's wheelchair out of the dining room and down the hall, opposite direction from his room and placed him outside of another resident's room where V8 and V9/CNAS were providing care to another resident. At that time, V1 verified that V6/RN should have assisted R7 with his toileting needs.		