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	02/09/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was assessed for injury after a fall and prior to being transferred for 1 of 3 residents (R1) reviewed for post-fall assessments in the sample of 3.The findings include:R1s admission record documents she was admitted to the facility on [DATE] with a primary diagnosis of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The 12/12/25 incident report for R1 shows she was ambulating in hallway and was behind double doors, door bumped into R1 causing change of plane. Under injuries it was indicated R1 had discomfort to right side.On 2/7/26 at 2:33 PM, V13 Dietary cook said she was taking the lunch cart into the unit. She put the code in and did not see R1 behind the door. She said R1 was right by the crack of the door and the wall and did not see her before pushing open the door. When she entered the unit, R1 fell. V13 said after R1 fell, she went to get V11 Certified Nursing Assistant (CNA). V13 said with V11, they picked R1 up from the floor and stood R1 up and placed her in a wheelchair. She said R1 was able to bear weight on one leg. She then went to tell the nurse about the fall. V13 said it was not safe to transfer R1 without a gait belt and could have hurt her more, and she should not have moved her without the nurse assessing her first. On 2/7/26 at 2:09 PM, V11 said when she arrived to R1 after the fall, V13 was standing by the double doors and R1 was sitting on the floor. She grabbed a wheelchair and stood R1 up and put her into the wheelchair. V11 said she realized her mistake after it happened and did not use a gait belt. And moving her before the nurse was able to assess her could make any injury worse. On 2/7/26 at 9:32 AM, V6 LPN Licensed Practical Nurse said she was on break when R1 fell. When she arrived back on the unit, she found R1 sitting up in a wheelchair. She said the two aides got her up off the floor before she could be assessed. They should not have moved her prior to any assessment just in case she had a broken hip. V6 said she was not very happy about the situation. On 2/7/26 at 11:11 AM, V2 Director of Nursing said when a resident has a fall, the nurse should be performing an assessment first, including range of motion, check their pain level and vital signs. The resident should not be moved prior to this assessment. The point of range of motion is to assess for injury and if you move them prior, you could cause an injury or worsen any injury.The facility's 1/2026 policy for fall prevention program documents its purpose: To assure the safety of all residents in the facility, when possible. Transfer conveyances shall be used to transfer residents in accordance with the care plan. On 2/9/26, V2 said after a fall, the nurse initiates resident assessment and risk management on the electronic record which auto populates the assessment to be completed. There is no specific checklist for post fall.

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident was supervised in the dementia unit and away from the doors. This failure resulted in R1 being hit by the door for a second time, causing her to fall and fracture her hip. The facility failed to ensure a resident was safely transferred after a fall for 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 3.The findings include:R1s admission record documents she was admitted to the facility on [DATE] with a primary diagnosis of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The 12/12/25 incident report for R1 shows she was ambulating in hallway and was behind double doors, door bumped into R1 causing change of plane. Under injuries it was indicated R1 had discomfort to right side. The final report shows the 12/12/25 fall was witnessed. The 12/13/25 emergency room radiology report shows the right femur fracture and right hip dislocation.R1s care plan documents she has risk factors that require monitoring and intervention to reduce potential for self-injury. (devices, cognition, mood/behavior, safety awareness). Risk factors include Dementia, history of falls with right hip fracture. R1s care plan shows her to be a wanderer. Interventions include disguising exits, cover doorknobs and handles. Distract residents from wandering by offering pleasant diversions, structured activities, food, conversation, television, book.On 2/6/26 at 3:15 PM, V4 (R1s son/power of attorney) said R1 had been in the facility for about 2 years. She was fine physically she was able to walk around the dementia unit without any cane or walker. He said in December, she was on the unit and was hit by the door into the unit and this was the 2nd time she had been hit by the door. V4 said back in October when she was hit the first time, she had no injury and they said they were going to do something different with the door, and nothing had been done.On 2/7/26 at 2:33 PM, V13 Dietary cook said she was taking the lunch cart into the unit. She put the code in and did not see R1 behind the door. She said R1 was right by the crack of the door and the wall and did not see her before pushing open the door. When she entered the unit with the door open, R1 fell. V13 said R1 had previously been hit by the door and that is why there are signs to look before entering the unit. She said R1 tended to stand behind the door. V13 said after R1 fell, she went to get V11 Certified Nursing Assistant (CNA). V13 said with V11, they picked R1 up without a gait belt or any assistive devices and stood R1 up and placed her in a wheelchair. She said R1 was able to bear weight on one leg. She then went to tell the nurse about the fall. V13 said it was not safe to transfer R1 without a gait belt and could have hurt her more. On 2/7/26 at 2:09 PM, V11 said when she arrived to R1 after the fall, V13 was standing by the double doors and R1 was sitting on the floor. She grabbed a wheelchair and stood R1 up and put her into the wheelchair. V11 said she realized her mistake after it happened and did not use a gait belt. And moving her before the nurse was able to assess her could make any injury worse. On 2/7/26 at 9:32 AM, V6 LPN Licensed Practical Nurse said R1 was able to ambulate around the unit on her own. She said this was the 2nd time R1 had been hit by the doors. That is why the signs are up on the door to look before entering the unit. On 2/7/26, each of the double doors to the dementia unit had a long narrow window and the common area of the unit was visible. When looking through the window the areas behind the door are visible. Signs on the door remind staff and visitors to look prior to opening the doors. On 2/7/26 at 11:11 AM, V2 Director of Nursing said this was the second time R1 had been bumped by the door. She had no injury from the first fall, and that is when the signs were put up to remind people to look before opening the door. On 2/9/26 at 8:47 AM, V2 said after the first incident staff were in-serviced about looking through the window to check for residents, and the signs were (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	posted. After the fall, the staff should have used the mechanical lift to move R1 from the floor to a wheelchair.The facility's 12/2025 policy for transfers- manual gait belt and mechanical lifts documents Mechanical lifting devices shall be used for any resident needing a two person assist, or who cannot be transferred comfortably and/or safely by normal transfer technique. Except during emergency situations or unavoidable circumstances, manual lifting is not permitted.