STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000293	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA CARE ALEDO	**304 S.W. 12TH STREET , ALEDO, Illinois, 61231**

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S0000	Initial Comments Investigation of Facility Reported Incident of 9/1/25-2614917 Investigation of Facility Reported Incident of 9/18/25-2636949 Investigation of Facility Reported Incident of 9/19/25-2637047 Investigation of Facility Reported Incident of 9/20/25-2637074 Statement of Licensure Violations: 300.610a) 300.1210b) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S0000		12/02/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S0000	Continued from page 1 Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These regulations were not met as evidence by: 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. The findings include: 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.	S0000		

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S0000	Continued from page 2 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.	S0000		

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S0000	Continued from page 3 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 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.'	S0000		

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S0000	Continued from page 4 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 over heard 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. (B)	S0000		