

Illinois State Department of Health

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 02/09/2026	
NAME OF PROVIDER OR SUPPLIER ARCADIA CARE ALEDO				STREET ADDRESS, CITY, STATE, ZIP CODE 304 S.W. 12TH STREET , ALEDO, Illinois, 61231			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments Complaint Investigation Survey: 25212368/2694518- F684, F689 26205333/2715756- F684, F689		S0000			02/10/2026	
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 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 300.1210b) 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.		S9999			02/10/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This requirement is NOT met as evidenced by: 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 4/13/24 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			S9999			

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S9999	Continued from page 2 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 posted. After the fall, the staff should		S9999				

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S9999	Continued from page 3 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. (A)		S9999				