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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Arcadia Care Havana		STREET ADDRESS, CITY, STATE, ZIP CODE 609 North Harpham Street Havana, IL 62644	

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 0557 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to reasonably accommodate a resident's request to electronically monitor her own room for one resident (R1) and the facility failed to allow one resident (R3) to electronically monitor his own room of two residents reviewed who had requested electronically monitor their rooms. The State of Illinois Ombudsman Program Booklet documents You have a right to purchase and use an electronic monitoring device after providing notice to the facility using the Electronic Monitoring Notification Consent Form.1.R1's Medical Record documents that she was admitted on [DATE] with diagnosis to include but not limited to hemiplegia and hemiparesis following a cerebral infarction, anxiety and restless leg syndrome. R1's Medical Record documents that she is cognitively intact and makes all of her own decisions. Throughout the survey R1 was alert, oriented and answered all questions appropriately. On 3/12/25 at 9:00 AM R1 stated that she had asked V16 (Social Services Director) about electronically monitoring her own room. I've signed a consent; they keep telling me they are waiting to hear back from corporate. They gave me a long list of things I had to do to be able to put a video camera in my room. I feel like they are intentionally making it hard for me to do because they don't want to be recorded and that is not fair. On 3/12/26 at 9:30 AM V16 (Social Services Director) confirmed that R1 had asked about electronic monitoring. I was told by corporate that if residents want to electronically monitor their rooms they have to sign a consent, which (R1) did willingly, and the resident has to pay a professional to install the camera, the resident cannot use facility wi-fi, they must set up their own internet service and that the residents have to have a security company that will monitor the feed for the resident.An email from V17 (Compliance Officer) to V16 (Social Services Director) documents What internet provider is the resident going to use? (a) Use of a Wi-fi: For security purposes, use of Facility's existing private or existing guest Wi-Fi network for purposes of transmitting data to or from an Electronic Monitoring Device is prohibited. If an Electronic Monitoring Device is found to be connected to a Facility's private or guest Wi-Fi, the Electronic Monitoring Device will be turned off and the Resident or Resident's Representative will be advised that the resident is responsible for providing and contracting with an internet service provider if they elect to have electronic monitoring device that uses internet technology.On 3/12/26 at 10:00 AM V16 (Social Services Director) confirmed that the Maintenance Director is usually the person responsible for hanging resident's wall decorations and/or pictures. V16 (Social Services Director) confirmed that all residents currently have access to the Facility's Wi-Fi for their phones or laptops at no charge. V16 (SSD) confirmed that no resident has ever requested to know what the security on the internet provider was. V1 stated that R1 uses her phone independently all the time and is able to navigate connecting it to and from wi-fi. V16 (SSD) stated that she thought R1 would be able to navigate a user friendly electronic monitoring device. 2. R3's Medical Record documents that he was admitted to the facility on [DATE] with diagnosis to include but not limited to Multiple Sclerosis, Chronic Pain and Post Traumatic Stress Disorder. R3's Medical Record documents that he is cognitively intact and makes all of his own decisions. On 3/12/26 at 9:30 AM R3 stated that he was using Bluetooth on his phone to connect to his TV so he could play his games better. R3 (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

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F 0557 Level of Harm - Actual harm Residents Affected - Few	stated that he mentioned to one of the CNAs that if he wanted to, he would be able to look inside of his own room through his TV on his phone. R3 stated I used to work for Google, so I am pretty computer and internet savvy. R3 stated I get out of bed very rarely, I am always in my room, so I was really just pointing it out, but then (V16/Social Services Director) came in and told me I am not allowed to monitor my room without a consent so I said ok, I will sign that, then she said I had to be on my own internet provider even though my system wasn't even using the internet. Now it's just a matter of what is right to do. I don't think they should be able to make me incur costs to monitor my own room. On 3/12/26 at 10:00 AM V16 (Social Services Director) confirmed she told R3 that he could not monitor his room via Bluetooth on his phone. V16 (SSD) stated can't monitor his room with Bluetooth. It must be on his own internet provider with a security company monitoring it for him.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review the facility failed to ensure seven residents (R1 through R7) were free from abuse of seven residents reviewed for abuse.This failure caused the residents to initially feel fear for their safety and has caused ongoing stress and anxiety.Findings include:The Facility's Abuse Prevention and Reporting policy dated 10/2022 documents This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, and deprivation of goods and services by staff or mistreatment. The Facility's Abuse Prevention and Reporting policy documents Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental mean. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish to a resident. This assumes that all instances of abuse of residents, even those in a coma, cause physical harm or pain or mental anguish. The Facility's Abuse Prevention and Reporting policy documents 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 may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. The Facility's Abuse Prevention and Reporting policy documents Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats or coercion.1.The Facility's Final Abuse Investigation Report dated 1/23/26 documents that on 1/18/26 V5 (Certified Nurse Aide) pushed facility staff member with residents present. On 3/11/26 at 11:30 AM V7 (Certified Nurse Aide) said that on 1/18/26 she overheard yelling and cursing so she walked up the hallway to see V8 (Registered Nurse) walking behind V5 (Certified Nurse Aide) who was yelling and cursing. V7 said there were residents out in the hallway and even those in their rooms could hear her. V7 (CNA) stated I said something to the effect of you are scaring the residents and I heard her say I will kick your a*s too, you stupid mother*ucker. V7 (CNA) said V5 (CNA) grabbed her by her throat and lifted her in the air I literally could not feel ground beneath my feet and slammed her into a door then threw her to the floor. V7 (CNA) stated It was the most violent and scariest thing I have ever been through. V7 said I was just worried about the residents because of the way she was acting. On 3/11/26 at 1:00 PM V8 (Registered Nurse) said that on 1/18/26 V5 (CNA) was the CNA responsible for staying in the main dining room during meals. V8 (RN) saw V5 (CNA) at the nurse's desk so she said, You need to be in the dining room and V5 stated I ain't doing sh*t, I'm fixing to leave. V8 (RN) stated I told her if she wasn't going to report to the dining room immediately, she should go ahead and leave early and she exploded. V8 (RN) stated that V5 (CNA) stated she wasn't leaving until I get my f*cking money b*tch. Get me my money you stupid mother*ucker. V8 (RN) stated she called the on-call person who pushed through V5 (CNA)'s payment for time worked and told V5 (CNA) that she could leave since she had been paid. V8 (RN) said that V5(CNA) began walking towards the door and yelled about what a sh*thole the facility was and that the facility f*cking needed her, you stupid b*tch. V8 (RN) said she was in my face at a couple points, and she was just being as vile as she possibly could. V8 (RN) said that V7 (CNA) came around the corner and said, please quit yelling you are scaring the residents. V8 (RN) said that V4(CNA) grabbed V7 (CNA) by the throat and slammed her into a doorway and then flung V7 (CNA) to the ground. When someone yelled call 911 V7 (CNA) ran out while spitting on (staff).The Facility's Final Abuse Investigation dated 1/23/26 documents It was witnessed that (V4/CNA) raised her voice, used profanity, and pushed (V7/CNA) with residents present during the exchange. No residents were involved in the altercation.On 3/10/26 at 1:30 PM V1 (Administrator) stated that the abuse allegation for the 1/18/26 incident would be considered not substantiated because no residents were involved in the altercation. On 3/12/26 at 10:00 AM R1 recalled V4 (CNA) beating up V7 (CNA). R1 stated that V5 (CNA) was (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	yelling and cursing, it was very scary.On 3/11/26 at 12:00 PM R2 recalled the incident on 1/18/26. R2 stated I didn't see how it all got started, when I got out there (V7/CNA) was on the ground holding her neck and crying and there were people everywhere. I am a big man with a rough past, I don't worry for myself, I am still able to take of myself, I worry about the people who can't take care of themselves if this is the kind of staff they (facility) are hiring.On 3/11/26 at 9:30 AM R3 recalled the incident on 1/18/26. R3 stated I wasn't out there for any of it, but the whole building was tense for the rest of the night. R4's nurse's note dated 1/20/26 at 10:46 AM as 72 hour Follow Up documents resident is alert and oriented. Has sad and worried look on his face.R5's nurse's note dated 1/18/26 at 6:46 PM documents resident alert and oriented. resident had episodes of crying. Resident verbalized being fearful related to being a witness to altercation between 2 CNAs. On 3/11/26 at 12:15 R6 recalled the incident on 1/18/26. (V7/CNA) was on the floor crying. Boy, I did not like that. R7's nurse's notes 1/19/26 at 2:53 PM document that R7 stated he was struggling with having been a witness to an altercation between two CNAs. 'I'm so mad about it.' Resident was in a safe space and that behavior like that was not tolerated and would not happen again. R7 had discharged home sometime after the incident and did not answer any phone calls made to the listed home phone during the survey.On 3/12/26 at 10:00 AM V1 (Administrator) stated the whole building was in an uproar over this incident. 2. The Facility's Final Abuse Investigation dated 3/6/26 documents that R2 told V1 (Administrator) that he had loaned V3 (Certified Nurse Aide) $50 and that she wasn't paying it back.On 3/10/26 at 9:45 AM R2 stated that V3 (CNA) had been complaining about her money situation so R2 offered her a loan. R2 stated at the time he only had a $50 bill on him so that is what he gave V3. R2 said he's unsure of exact day but it was about 2 weeks ago. The Facility's undated interviews with residents document that when asked, R3 stated that V3 (CNA) had asked him for money but he said no.On 3/10/26 at 10:00 AM R3 stated that a couple of weeks ago V3 (CNA) asked him for money but he said no. On 3/10/26 at 1:30 PM V1 (Administrator) stated that abuse allegation related to R2's concern about his money was considered unsubstantiated because R2 could not prove that he actually gave the staff member money. V1 (Administrator) stated that R2 handled his own finances therefore V1 (Administrator) could not prove that R2 even had $50 to loan in the first place.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. Based on interview and record review the facility failed to recognize allegations of abuse as substantiated instances of abuse. This failure has the potential to affect all 56 residents who currently reside in the facility. The Facility's Abuse Prevention and Reporting policy dated 10/2022 documents This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, and deprivation of goods and services by staff or mistreatment. The Facility's Abuse Prevention and Reporting policy documents Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental mean. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish to a resident. This assumes that all instances of abuse of residents, even those in a coma, cause physical harm or pain or mental anguish. The Facility's Abuse Prevention and Reporting policy documents 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 may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. The Facility's Abuse Prevention and Reporting policy documents Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats or coercion.The Facility's Final Abuse Investigation dated 1/23/26 documents It was witnessed that (V5/CNA) raised her voice, used profanity, and pushed (V7/CNA) with residents present during the exchange. No residents were involved in the altercation.On 3/12/26 at 10:00 AM R1 recalled V5 (CNA) beating up V7 (CNA). R1 stated that V5 (CNA) was yelling and cursing, it was very scary.On 3/11/26 at 12:00 PM R2 recalled the incident on 1/18/26. R2 stated I didn't see how it all got started, when I got out there (V7/CNA) was on the ground holding her neck and crying and there were people everywhere. I am a big man with a rough past, I don't worry for myself, I am still able to take of myself, I worry about the people who can't take care of themselves if this is the kind of staff they (facility) are hiring.On 3/11/26 at 9:30 AM R3 recalled the incident on 1/18/26. R3 stated I wasn't out there for any of it, but the whole building was tense for the rest of the night. R4's nurse's note dated 1/20/26 at 10:46 AM as 72 hour Follow Up documents resident is alert and oriented. Has sad and worried look on his face.R5's nurse's note dated 1/18/26 at 6:46 PM documents resident alert and oriented. resident had episodes of crying. Resident verbalized being fearful related to being a witness to altercation between 2 CNAs. On 3/11/26 at 12:15 R6 recalled the incident on 1/18/26. (V7/CNA) was on the floor crying. Boy, I did not like that. R7's nurse's notes 1/19/26 at 2:53 PM document that R7 stated he was struggling with having been a witness to an altercation between two CNAs. 'I'm so mad about it.' Resident was in a safe space and that behavior like that was not tolerated and would not happen again. R7 had discharged home some time after the incident and did not answer any phone calls made to the listed home phone during the survey.On 3/10/26 at 1:30 PM V1 (Administrator) stated that the abuse allegation for the 1/18/26 incident would be considered not substantiated because no residents were involved in the altercation. V1 confirmed that there were 5 residents (R2 through R7) were in the hallway and witnessed V5 (CNA) attack V7 (CNA). V1 also confirmed that it was reported to her that V5 (CNA) was screaming, cursing and threatening anyone who tried to calm her down. V1 stated None of the residents were within arm's reach of (V5/CNA) and (V4/CNA) didn't specifically state she was going to hurt a resident. (V5/CNA) was mad at the nurse. 2. The Facility's Final Abuse Investigation dated 3/6/26 documents that R2 told V1 (Administrator) that he had loaned V3 (Certified Nurse Aide) $50 and that she wasn't paying it back.On 3/10/26 at 9:45 AM R2 stated that V3 (CNA) had been complaining about her money situation so R2 offered her a loan. R2 stated at the time he only had a $50 bill on him so that is what he gave V3. R2 said he unsure of exact day but it was about 2 weeks ago. The Facility's interview form with abuse questions dated 3/6/26 had a handwritten note at the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	bottom from V15 (Regional Director of Operations) documenting (V3/CNA) refused to show for interviews and made herself unavailable. Throughout the survey messages were left at multiple phone numbers for V3(CNA) with no return phone call. The Facility's undated interviews with residents document that when asked, R3 stated that V3 (CNA) had asked him for money but he said no.On 3/10/26 at 10:00 AM R3 stated that a couple of weeks ago V3 (CNA) asked him for money but he said no. On 3/10/26 at 1:30 PM V1 (Administrator) stated that abuse allegation related to R2's concern about his money was considered unsubstantiated because R2 could not prove that he actually gave the staff member money. V1 (Administrator) stated that R2 handled his own finances therefore V1 (Administrator) could not prove that R2 even had $50 to loan in the first place. V1 (Administrator) confirmed that R2 is alert and oriented and does not have a history of fabricating stories for any reason and is usually pretty laid back, get along with everyone kind of guy. V1 (Administrator) confirmed that she was made aware that during the investigation into V3 taking money from R3 had also reported that V3 (CNA) had asked him for money also. No one can prove that, that is just hearsay. V1 (Administrator) confirmed that R3 is alert and oriented and does not have a history of fabricating stories for any reason. It still shouldn't be considered abuse because it is not misappropriation of funds, (R2) offered the money on his own accord. On 3/10/26 at 9:00 AM V1 (Administrator) confirmed she was the Abuse Coordinator for the facility. The facility's Resident Census and Condition list dated 3/10/26 documents 56 residents currently reside in the facility.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review the facility failed to ensure all Certified Nurse Aides had 12 hours of required In-Service Training. This failure has the potential to affect all 56 residents who currently reside in the facility. The Facility's (Temporary Agency) Client Service Agreement dated 6/30/2023 documents (Facility) acknowledges that Professional Providers are independent contractors operating as self-employed individuals who use (Temporary Agency) to offer and provide healthcare services to (Facility). (Facility) acknowledges and agrees that (Temporary Agency) has no responsibility for, control over, or involvement in the scope, nature, quality, character, timing or location of any work or services performed by Professional Providers between (Facility) and Professional Providers. (Facility further represents, acknowledges, and warrants that throughout the term it shall at all times treat Professional Providers as independent contractors and (Facility) will take no action that is inconsistent with such classification. The Facility's (Temporary Agency) Client Service Agreement also documents (Facility) hereby acknowledges and agrees that (Temporary Agency) is not the employer of, or joint employer or integrated or single enterprise with any Professional Provider. (Facility) understands and agrees that through the term (Temporary Agency) is not responsible for the performance or non-performance of any Professional Provider. On 3/12/26 at 9:00 AM V1 (Administrator) stated she did not have any documentation of any trainings done by (Temporary Agency) staff. I know that (Temporary Agency) keeps that on file. On 3/12/26 at 10:00 AM V1 (Administrator) stated that she would not be able to provide any documentation of any trainings done by (Temporary Agency) staff. V1 confirmed that about 50 % of the Certified Nurse Aide staff was from (Temporary Agency) On 3/12/26 at 10:00 AM R1 stated (Agency) staff are horrible, they don't seem to know what is going on.On 3/11/26 at 12:00 PM R2 stated (Agency) staff don't care and have no idea what they are doing. On 3/12/26at 9:30 AM R3 stated (Agency) staff don't know anything about (the residents) and they always do the bare minimum.