

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 04/27/2026
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the Facility failed to maintain safe/functioning locks on a bed and maintain a clear pathway to prevent two separate falls for one of seven Residents (R4) reviewed for Falls in a sample of seven. Findings include: The Facility Fall Prevention Program Policy, dated 1/2026, documents: to assure safety of all residents in the Facility when possible; the program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary; methods to identify risk factors; use and implementation of professional standards of practice; adherence to manufacturer's recommendation in use of medical devices and special care equipment; identification of all risk/issues; preventative measures; the environment will be kept clear of clutter which would affect ambulation and remove hazards; and the bed locks will be checked to assure they are in the locked position at all times. The Facility Incidents by Incident Type Report, dated 4/25/26, documents R4's witnessed fall incident (3/30/26 and 4/8/26) and un-witnessed fall incident (4/23/26). R4's current Care Plan documents diagnoses including History of Transient Ischemic Attack/TIA; Cerebral Infarction; Age-Related Osteoporosis without pathological fracture; Alzheimer Disease; Muscle Wasting and Atrophy; Protein Calorie Malnutrition, Generalized Anxiety Disorder; Unspecified Dementia with Psychotic Disturbance and Depressive Disorder. R4's current Care Plan documents: has impaired visual function related to poor eyesight; receiving anti-psychotic medications; is at risk for falls related to dementia; requires supervision to partial/moderate assist for activities of daily living/ADL; alter/remove any potential causes if possible; anticipate and meet the resident's needs; be sure the call light is within reach and encourage the resident to use it for assistance as needed; bolsters/scoop mattress to bed to help define edges; and ensure that the resident is wearing appropriate footwear. R4's Minimum Data Set/MDS, dated [DATE], documents severe cognitive loss on a Brief Interview for Mental Status/BIMS (score 4/15) and requires partial/moderate staff assistance with ADL's (bed mobility and transfers). R4's Progress Notes, dated 3/30/26, documents R4 was sitting on floor at bedside next to bed and that R4 had been ambulating in the hall prior to the fall. R4 stated at the time that R4 was going to lay down in bed the bed moved and R4 rolled out of bed onto the floor. R4's Progress Notes, dated 3/31/26, documents after the Interdisciplinary Team review, the root cause was determined to be that R4's bed brakes were not locked, and the intervention was for V15 (Maintenance Director) to repair the bed locks. R4's Progress Notes, dated 4/9/26, documents after the Interdisciplinary Team review, the root cause was determined to be that R4 was ambulating and tripped on a (mechanical lift) and the intervention was to store the mechanical lift in the clean utility room when not in use. R4's Witnessed Fall Report, dated 3/30/26, documents: observed sitting up on floor beside bed; no debris on floor; had been up ambulating in hall prior; sat on bed and was getting ready to lay down when the bed moved away; bed was not in locked position; stated was going to lay down and fell off of the bed. The Fall Report intervention documents V15 (Maintenance Director) was notified to repair the bed lock. No injuries were noted. R4's Witnessed Fall Report, dated 4/8/26, (continued on next page)</p>		

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>documents: R4 was attempting to exit a nearby door and tripped over a mechanical lift that was in the D Hall walkway when R4 was ambulating the halls. R4 was found on the D Hall floor with R4's legs between the mechanical lift legs. The Fall Report documents R4 is confused and has impaired memory, uses antipsychotic medication, is an active exit seeker/ wanders, is restless and has behavior symptoms. No injuries were noted. On 4/25/26 at 11:50 am, V2 (Director of Nursing) stated, (R4's) brake was broke on R4's bed when (R4) fell out of bed on the 3/30/26 fall so we had to have (V15/Maintenance Director) fix it because it would not lock. On the 4/8/26 fall, (R4) is known to walk around the Facility and (R4) tripped over a (mechanical lift) that was in the hallway. The staff should know that they need to keep the hallways clear of equipment so that does not happen.</p>		

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<p>F 0777</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to obtain a physician ordered MRI (Magnetic Resonance Imaging) for one of seven residents (R1) reviewed for pain in the sample of seven. Findings include: The facility's Physician Notification of Laboratory/Radiology/Diagnostic Results dated 12/2025 documents, Purpose: To ensure physician ordered diagnostic tests are performed, and to assure test results are reported to the physician so that prompt, appropriate action may be taken if indicated for the resident's care. A licensed nurse is responsible for assuring the laboratory is notified of physician's orders for testing and for monitoring receipt of test results. R1's Pain Clinic Progress Notes dated 3/19/26 and signed by V10 (Pain Specialist) document, (R1) is an [AGE] year-old presenting with pain that is predominately left cervical and right knee. Stenosis was noted in the cervical region. (R1) pain she graded 10/10 (severe pain) with a range of 4-10 with tenderness, exhausting, penetrating, miserable, and tiring pain which interferes with general activity, mood, walk, sleep, enjoyment of life and relations with people. It's aggravated with sitting as well as lying down and physical activity. Treatment: Imaging: MRI C-Spine (Cervical Spine) Neck without contract. R1's Pain Clinic Progress Notes dated 4/16/26 and signed by V10 (Pain Specialist) documents R1 did not get the MRI as ordered on 3/19/26. On 4/24/26 at 1:35 PM V12 (V10's Medical Assistant) stated, (R1) came to our pain clinic on 4/16/26 for a follow-up. The facility did not do (R1's) MRI as ordered on 3/19/26. On 4/24/26 at 1:55 PM V14 (Hospital X-Ray Technician) stated, Just a few minutes ago, (V5/Social Service Director) called here to ask for (R1's) MRI results. I informed (V5) that (R1) was supposed to get her MRI yesterday and on 4/9/26, but (R1) did not show up. (R1) had not had an MRI yet. V5 had to re-schedule (R1's) MRI for 4/20/26. On 4/24/26 at 2:02 PM V5 (Social Service Director) stated, I was not made aware that (R1) did not get her MRI on 4/9/26 as scheduled. There is no documentation why (R1) did not get the MRI on 4/9/26. I am the scheduler and was not made aware that (R1's) MRI was re-scheduled for 4/23/26, therefore (R1) has not received the MRI yet.</p>		