STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145774	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Havana	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure allegations of abuse and injury of unknown origin were thoroughly investigated, documented, and reported timely for one (R11) of three residents reviewed for abuse in the sample list of 41. Findings include:The facility's Abuse Prevention and Reporting policy revised 3/2026 documented the facility affirms residents have the right to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff, and mistreatment. The policy documented nursing staff are responsible for reporting suspicious bruises, lacerations, or abnormalities as they occur. Upon reporting such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing documentation, and reporting to the administrator or designee. The policy further documented that employees accused of abuse, neglect, exploitation, or mistreatment shall be removed from resident contact immediately pending investigation results. All incidents were to be documented whether abuse, neglect, exploitation, mistreatment, or misappropriation occurred, was alleged, or suspected.The facility's Transfer-Manual Gait Belt and Mechanical Lifts policy revised 8/2023 documented mechanical lifting devices shall be used for residents requiring a two-person assist or who cannot be transferred safely by normal transfer techniques. The policy further documented mechanical lifts requires two caregivers for transfers.R11's Minimum Data Set (MDS) dated [DATE] documents R11 is cognitively intact and dependent on staff for all activities of daily living.R11's Skin assessment dated [DATE] documents purple discoloration measuring four centimeters(cm) by four centimeters to the left ankle.On 5/4/26 at 9:20 AM, R11 stated V6 (Certified Nursing Assistant/CNA) transferred R11 with a mechanical lift alone at approximately 8:30 PM on a Friday night (4/17/26). R11 stated while suspended in the lift, V6 attempted to open the legs of the mechanical lift and smashed R11's left foot between the wall and the door. R11 stated he told V6 his foot was smashed, but V6 continued the transfer and told R11 he was fine. R11 stated he notified V5 (Registered Nurse) immediately after the incident because R11's foot hurt. R11 stated V1 (Administrator) and V2 (Director of Nursing) later spoke with him on Monday (4/20/26) and photographed the bruise on R11's left ankle. R11 additionally stated V6 previously made inappropriate comments to R11 regarding pierced nipples and not wearing a bra. R11 stated he reported these comments previously to V2 Director of Nursing, but staff laughed it off.On 5/4/26 at 11:27 AM, V5 (Registered Nurse/RN) stated V6 came out of R11's room yelling, I'm not arguing with you. V5 stated she did not witness V6 transferring R11 or observe R11's foot being injured because V5 was not in the room. V5 stated she informed V1 of the incident but was not asked to complete a witness statement or have staff complete a witness statement. V5 stated the witness statement completed later by V1 did not accurately reflect what V5 reported to V1 because V5 informed V1 she had not witnessed the event. V5 stated she believed V6 was alone with R11 during the transfer because another unknown CNA had left the room. V5 acknowledged she did not report the incident to outside agencies, did not document the event, and did not complete an assessment because she didn't think R11 was that hurt. V5 stated R11 was alert and oriented.On 5/4/26 at 1:12 PM, V6 (CNA) stated she transferred R11 with the mechanical lift while V5 was passing medications in the hallway. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145774	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Havana	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V6 confirmed R11 yelled, My foot got stuck. V6 stated she completed the transfer, placed R11 in bed, and then obtained V5 (RN) because V6 wasn't going to tolerate R11's lies. V6 stated she told R11 to stop lying. V6 stated R11 made her uncomfortable and described him as a weirdo. V6 stated she never reported concerns regarding resident comments or behaviors. V6 further stated I'm (V6) glad I don't work at that place and have to see R11 anymore.The facility staffing schedule documents V6 (CNA) and V5(RN) worked second shift on 4/17/26. The schedule documented V6 continued to work on 4/18/26 and 4/19/26 and was removed from the schedule on 4/20/26 pending investigation.R11's electronic medical record did not contain documentation of an assessment, progress note, physician notification, family notification, incident report, or investigation regarding the reported injury sustained during the transfer on 4/17/26.On 5/4/26 at 1:42 PM, V12 (Social Services Director) stated on 4/20/26 R11 informed V12 that V6 transferred him alone with a mechanical lift and injured his foot by smashing it between the wall and the door. V12 stated she observed a dark, baseball-sized bruise on R11's left ankle and reported the allegation to nursing staff and V1. V12 further stated R11 previously reported inappropriate comments made by V6 and V12 reported those concerns to V2; however, she doubted the allegations were investigated.On 5/4/26 at 1:53 PM, V2 (Director of Nursing) stated she had previously received abuse allegations from R11 regarding V6 but was unable to locate grievances or documentation related to those prior allegations.On 5/5/26 at 10:59 AM, V1 (Administrator) stated the incident should have been reported and documented on 4/17/26 by V5 (RN). V1 stated she was not made aware of the allegation until 4/20/26 after V12 spoke with R11.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145774	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Havana	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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure allegations of abuse and injury of unknown origin were reported and thoroughly investigated timely for one (R11) of three residents reviewed for abuse in a sample list of 41. Findings include:The facility's Abuse Prevention and Reporting policy revised 3/2026 documented nursing staff are responsible for reporting suspicious bruises, lacerations, or abnormalities as they occur. The policy further documented incidents involving allegations or suspicions of abuse or mistreatment were to be documented and reported to the administrator or designee for investigation.R11's Skin assessment dated [DATE] documented purple discoloration measuring four centimeters by four centimeters to R11's left ankle.On 5/4/26 at 9:20 AM, R11 stated V6 (Certified Nursing Assistant/CNA) injured R11's left foot during a transfer on 4/17/26. R11 stated he immediately reported the incident to V5 (Registered Nurse/RN) because his foot hurt. R11 stated V1 (Administrator) and V2 (Director of Nursing) did not speak with him regarding the incident until 4/20/26.On 5/4/26 at 11:27 AM, V5 (RN) stated V6 informed V5 of the incident on the night it occurred. V5 acknowledged she did not document the incident, complete an assessment, or report the allegation for investigation because she didn't think R11 was that hurt.R11's electronic medical record did not contain documentation of an incident report, assessment, abuse investigation, physician notification, family notification, or report to the administrator regarding the alleged injury occurring on 4/17/26.On 5/4/26 at 1:42 PM, V12 (Social Services Director) stated R11 informed V12 on 4/20/26 that V6 injured his foot during a transfer on 4/17/26. V12 stated she observed a dark bruise to R11's left ankle and reported the allegation to nursing staff and V1.On 5/5/26 at 10:59 AM, V1 (Administrator) stated the incident should have been reported and documented on 4/17/26 and V1 was not made aware of the allegation until 4/20/26 after V12 notified V1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145774	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Havana	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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify, assess, and treat pressure ulcers/wounds, failed to prevent pressure ulcers/wounds from worsening, failed to develop and implement pressure relieving interventions and a pressure ulcer care plan, failed to ensure pressure ulcer care and treatment was provided in accordance with professional standards of practice, failed to implement and maintain infection control practices during wound care, failed to maintain clean wound care supplies and treatment surfaces, and failed to ensure ordered dressing changes were completed as prescribed for three (R1, R11, and R12) of four residents reviewed for pressure ulcers in the sample of 41. These failures resulted in worsening, infected pressure ulcers requiring debridement, multiple hospitalizations, increased pain requiring opioid medication, treatment with intravenous (IV) and oral antibiotics, and hospice admission related to pain management and wound infection for R1. Findings include: The facility policy titled, Pressure Ulcer Prevention, dated 12/2025, documented the purpose of the policy was to prevent and treat pressure sores/pressure injuries. The policy further documented staff were to maintain clean and dry skin during hygiene measures; inspect skin several times daily during bathing, hygiene, and repositioning; keep linens dry and wrinkle free; reposition dependent residents approximately every two hours or as needed; utilize pillows, pads, and positioning devices to protect bony prominences and reduce friction and shearing; utilize pressure reducing mattresses for residents at risk; utilize specialty mattresses for residents with multiple stage two wounds or one or more stage three or stage four wounds; utilize pressure reducing chair pads for residents identified as moderate/high/severe risk; encourage residents to reposition regularly; and provide nutritional and hydration support to promote skin integrity and wound healing. The facility policy titled, Dressing Change – (Clean/Non-Sterile), dated 12/2025, documented staff were to prepare a clean, dry work area prior to beginning wound care; disinfect bedside surfaces or place a protective barrier prior to placing wound care supplies on surfaces; perform hand hygiene prior to wound care; remove soiled gloves and perform hand hygiene after removal of old dressings; apply clean gloves prior to cleansing wounds; observe wounds for signs and symptoms of infection; apply prescribed dressings per physician order; utilize separate gloves and perform hand hygiene between each wound site because each wound was considered a separate treatment; prevent contamination of clean dressing supplies; initial and date dressings; and sanitize bandage scissors after use. The Glove Use- Nursing policy dated 1/26, documents non-sterile gloves shall be worn for procedures that require contact with blood or body fluids such as removing soiled dressings and non-sterile dressing changes. Gloves used for contact shall be removed and discarded after contact with each person, fluid item or surfaces. Hand hygiene will be performed after removing gloves. The Negative Pressure Wound Therapy (NPWT) Device Instructions for Use documents to ensure all components of the NPWT Wound Dressing Kit are installed correctly and that the port pad assembly tubing is not kinked to avoid leakage and blockage during NPWT therapy. Position the NPWT System and drainage tubing appropriately to avoid the risk of causing a trip hazard. When possible, position the pump device and drainage tubing at or below the level of the wound. The Med Aire Plus 8 Alternating Pressure and Low Air Loss Mattress operator's [NAME] documents to press the Static/Alternating button to operate the air mattress in Static mode or Alternating (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145774	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Havana	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 0686 Level of Harm - Actual harm Residents Affected - Few	Pressure mode. The Power Failure indicator, System Failure indicator and Low-Pressure indicator light (red) will [NAME] when there is no power input to the control unit, the system fails to alternate or the pressure is below the pre-defined level. Hang the control unit over the frame or at the foot of the bed and secure. It is recommended to always keep control unit in the Alternating Pressure mode when the patient is in position for more efficient pressure ulcer prevention and treatment. The Static mode provides an even support surface that will make the patient transfer or reposition easier. The facility's document, Medacure User Manual for Oasis Alternating Pressure Mattress, dated 2019, includes, Product Functions: 1) Pressure Adjust Valve: Adjust the valve to increase or decrease the pressure for a softer or firmer setting between 1-8 range or by patient's weight as noted on the panel. 2) Alternating/Static Mode Switch: Press this switch to adjust the mode from Alternating to Static. 1.R1's admission Record, reviewed on 5/5/26, documented diagnoses including paraplegia, obesity, diabetes, stage four pressure ulcers of the sacral region and right hip, osteomyelitis, and sepsis. R1's Braden Skin Risk Assessment, dated 1/27/25, documented R1 was at risk for pressure ulcer development; however, no preventative interventions were listed. R1's Quarterly MDS (Minimum Data Set) assessment, dated 4/7/26, documented R1 was dependent on staff for bed mobility, toileting, and personal hygiene, was at risk for developing pressure ulcers, and had two stage four pressure ulcers. R1's current Care Plan, reviewed on 5/6/26, documented R1 had a focus, initiated on 2/13/25, indicating R1 was at risk for skin impairment related to friction/shearing, paraplegia, morbid obesity, and diabetes with a goal to maintain or develop clean and intact skin by the review date. Interventions included: assess and record changes in skin status; monitor/document location, size and treatment of skin injury, report abnormalities, failure to heal, signs or symptoms of infection, maceration, etc. to physician; provide/monitor effectiveness of pressure relieving or reducing devices; report pertinent skin status changes to the provider; and treatment as ordered. This same care plan documented R1 had a focus, initiated on 5/5/25, stating R1 had an actual skin impairment related to friction/shearing, paraplegia, and diabetes with a goal for R1's wound to show signs of improvement through the review date. Interventions for this focus included: monitor site for signs or symptoms of infection, treatment as ordered, refer to infectious disease doctor for non-healing wounds, and wound doctor to evaluate and treat as ordered. On 5/4/26 at 9:33 AM, R1 was observed lying on his back with the head of the bed elevated approximately 45 degrees while his alternating pressure mattress remained in static mode. R1 stated he stayed in the same position most of the time and staff only sometimes offered repositioning. R1 stated he believed the mattress relieved pressure automatically. R1 further stated he had painful wounds, was recently hospitalized due to wound infection, and was currently receiving hospice services related to his wounds and pain. Point of Care (POC) documentation for the past 30 days and progress notes dating back to January 2026 were reviewed and failed to demonstrate staff consistently repositioned R1 every two hours or implemented alternative interventions when repositioning was refused. POC documentation reflected bed mobility and rolling left and right only one to three times daily with no consistent documentation of repositioning offers or refusals in either the POC documentation or progress notes. On 5/4/26 at 2:15 PM, V13/Licensed Practical Nurse (LPN) provided wound care to multiple pressure (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145774	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Havana	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 0686 Level of Harm - Actual harm Residents Affected - Few	ulcer sites for R1. R1's cloth pad and bed linens were soiled with a brown liquid and ring present. R1 has a suprapubic catheter and lower left quadrant colostomy. R1 had multiple wounds on each side of his buttocks and thighs. V13 started performing wound care by removing multiple old dressings to R1's left buttock and thighs with the same gloves on. The dressings were heavily saturated and soiled when R1 rolled on his right side and two of the dressings on R1's right buttocks and thigh were dated 5/2/26. V13 confirmed at this time that wound care and dressing changes were ordered daily to the wounds and the dressing should have been changed on 5/3/26, but it was not. Heavy blood drainage was present and draining down R1's leg and V13's gloves were visibly soiled with the bloody drainage. The left buttock wound was observed with black tissue at the wound base, and a foul odor was present. V13 measured R1's left buttock with a cotton tip applicator and stated it was 2.5 cm (centimeters) deep with tunneling present at 10 o'clock that measured 4.0 cm. V13 stated R1's left buttock wound bed extended to the bone and was black in color with necrosis and slough at the wound base. Using the same soiled gloves, she used to remove the old, soiled dressing, V13 picked up clean gauze moistened with cleaning solution from a soiled counter containing debris and proceeded to cleanse R1's left buttock and left thigh wounds with these gloves on, moving from the left buttock wound to the left thigh wound with the same gauze. V13 then with the same soiled gloves to pack R1's left buttock wound bed with a new clean, primary dressing and touched the inside of the secondary dressing with the soiled gloves before she applied the same dressing to both the left buttock and left thigh wounds. R1's left buttock wound was not completely covered after V13 finished the dressing change. During the wound care observation, R1's air mattress was in 'Static' mode. V13 stated R1's air mattress is always on this setting, and she does not mess with the settings. On 5/4/26 at 2:46 PM, V13/LPN confirmed she failed to perform hand hygiene and glove changes between contaminated and clean tasks, contaminated clean supplies, performed wound care to multiple wounds simultaneously, and used one dressing for two separate wounds. V13 acknowledged each wound required separate dressings and glove changes to prevent cross-contamination and further confirmed R1's left buttock wound was infected and required antibiotics. V13 stated, (R1's) air mattress is always on the 'Static' setting and I don't touch it. R1's Order Summary Report, dated 5/6/26, documented R1 had physician orders to receive daily wound care to multiple buttock and thigh wounds. R1's Treatment Administration Record for May 2026 failed to document wound care completion on 5/3/26 for R1's buttock and thigh wounds as ordered. Wound assessments completed by V19/Wound Care Nurse Practitioner between February 2026 and April 2026 repeatedly documented R1's left buttock stage four pressure ulcer was deteriorating noting in her weekly wound assessment: increasing measurements, heavy drainage, a strong odor, necrotic tissue, exposed bone and muscle, tunneling, and suspected osteomyelitis. V19's documentation further reflected ongoing infection concerns, recommendations for MRI evaluation, Infectious Disease consultation, systemic antibiotics, and wound deterioration despite treatment interventions being updated and ordered. R1's Multi Wounds Chart Details Report, dated 2/4/26, completed and signed by V19/Wound Care Nurse Practitioner, documented a wound assessment of R1's left buttock stage four pressure ulcer that measured 5.5 cm (centimeters) (length) by 5.0 cm (width) by 6.0 cm (depth) with tunneling at 10 o'clock measuring 6 cm. V19 documented R1's pressure ulcer to his left buttock was deteriorating and had heavy serosanguineous drainage (thin, watery drainage with a red or pink tint) with a strong odor. The wound had 71-80% slough and 11-20% grey tissue with muscle and bone exposure, muscle (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145774	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Havana	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 0686 Level of Harm - Actual harm Residents Affected - Few	necrosis, suspected osteomyelitis, and V19 documented she was awaiting results. This same assessment documented there were signs and symptoms of infection, systemic antibiotics were prescribed, and an x-ray was advised. R1's Multi Wounds Chart Details Report, dated 2/11/26, completed and signed by V19/Wound Care Nurse Practitioner, documented a wound assessment of R1's left buttock stage four pressure ulcer that measured 4.8 cm (centimeters) (length) by 6.0 cm (width) by 5.0 cm (depth) with tunneling at 10 o'clock measuring 6 cm. V19 documented R1's pressure ulcer to his left buttock was deteriorating and had heavy serosanguineous drainage (thin, watery drainage with a red or pink tint) with a strong odor. The wound had 71-80% slough and 11-20% grey tissue with muscle and bone exposure, muscle necrosis, suspected osteomyelitis, and V19 documented she was awaiting results. This same assessment documented there were signs and symptoms of infection, systemic antibiotics were prescribed, and an x-ray was advised on 2/4/26. R1's Multi Wounds Chart Details Report, dated 2/25/26, completed and signed by V19/Wound Care Nurse Practitioner, documented a wound assessment of R1's left buttock stage four pressure ulcer that measured 3.5 cm (centimeters) (length) by 4.5 cm (width) by 2.0 cm (depth) with tunneling at 10 o'clock measuring 5.4 cm. V19 documented R1's pressure ulcer to his left buttock was deteriorating and had heavy serosanguineous drainage with a strong odor. The wound had 91-100% grey tissue with muscle and bone exposure, muscle necrosis, and V19 wrote she suspected osteomyelitis and was awaiting results. This same assessment documented there were signs and symptoms of infection, systemic antibiotics were prescribed, and an MRI (Magnetic Resonance Imaging) of the left hip and sacrum/coccyx was needed to rule out osteomyelitis. R1's Multi Wounds Chart Details Report, dated 3/4/26, completed and signed by V19/Wound Care Nurse Practitioner, documented a wound assessment of R1's left buttock stage four pressure ulcer that measured 4.2 cm (centimeters) (length) by 4.5 cm (width) by 1.7 cm (depth) with tunneling at 10 o'clock measuring 5.4 cm. V19 documented R1's left buttock pressure ulcer was deteriorating, had 91-100% grey tissue, exposed muscle and bone, and she suspected osteomyelitis and was awaiting results. V19 also documented the pressure ulcer had a strong odor with heavy serosanguineous drainage. R1's Multi Wounds Chart Details Report, dated 3/18/26, completed and signed by V19/Wound Care Nurse Practitioner, documented a wound assessment of R1's left buttock stage four pressure ulcer that measured 4.2 cm (centimeters) (length) by 4.5 cm (width) by 5.0 cm (depth) with tunneling at 10 o'clock measuring 5.0 cm. V19 documented heavy serosanguineous drainage with a strong odor, 1-10% eschar (hardened, dead tissue), 81-90% grey tissue, and exposure of muscle and bone with suspected osteomyelitis, awaiting results. V19 mechanically debrided tissue to R1's left buttock pressure ulcer on this same date and documented under assessment notes she ordered an MRI of the left hip and sacrum/coccyx, continue wound V.A.C. (Vacuum-Assisted Closure), labs to rule out infection, and referral to Infectious Disease for poor wound healing. R1's Multi Wounds Chart Details Report, dated 3/25/26, completed and signed by V19/Wound Care Nurse Practitioner, documented a wound assessment of R1's left buttock stage four pressure ulcer that measured 3.0 centimeters (cm) (length) by 4.0 cm (width) by 1.7 cm (depth) with tunneling at 10 o'clock measuring 5.0 cm. V19 documented heavy serosanguineous drainage with a strong odor, 1-10% eschar, 81-90% grey tissue, and exposure of muscle and bone with suspected osteomyelitis, awaiting results. V19 mechanically debrided tissue to R1's left buttock pressure ulcer on this same date and documented under assessment notes, Unable to determine. Inconclusive d/t (due to) testing and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145774	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Havana	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 0686 Level of Harm - Actual harm Residents Affected - Few	specialty consultation delays. A progress note, dated 3/25/26, documented R1 was transferred by ambulance to (local hospital emergency department) requested by V19/Wound Care Nurse Practitioner for evaluation of wounds. R1's Hospital History and Physical, dated 3/25/26, documented R1 was admitted inpatient to (local hospital) due to worsening sacral pressure ulcer from 3/25/26 to 4/10/26. This report documents R1 was found to have worsening bilateral sacral pressure ulcers extending to the bone. Sharp debridement was performed on 3/27/26 to remove non-viable tissue. An MRI (Magnetic Resonance Imaging) of the pelvis was done and confirmed osteomyelitis of left buttock wound. R1 was referred to Infectious Disease specialists and received intravenous (IV) antibiotics, fluids, and opioid pain medications while hospitalized . He was discharged back to the facility on 4/10/26 with orders for two oral antibiotics for six weeks due to osteomyelitis of left buttock pressure ulcer and continued wound care to pressure ulcers. A Progress Note, dated 4/15/26 at 10:17 AM, documented, (R1) continues to be disoriented, increased confusion, scrambling of words. Per wound doctor, new order received to send to (local hospital emergency department) for eval (evaluation) and treatment, per ambulance. R1's Hospital History and Physical, dated 4/15/26, documented R1 was admitted inpatient to (local hospital) from 4/15/26 to 4/21/26 for altered mental status and sepsis workup due to infected sacral pressure ulcer. R1 received intravenous (IV) antibiotics, fluids, and opioid pain medications while hospitalized . R1 was discharged back to the facility with orders to continue two oral antibiotics for osteomyelitis of left buttock pressure ulcer and continued wound care for pressure ulcers. A Progress Note, dated 4/22/26 at 2:56 PM, stated, This writer (V12/Social Services Director) met with resident to talk about resident's current wants. Resident wants to be comfortable without pain but states that he is in pain with his wounds. A Progress Note, dated 4/27/26 at 4:22 PM, documented, Hospice admitted resident with primary diagnosis of osteomyelitis. Received new orders focused on comfort care and pain management. R1's Order Summary Report, dated 5/5/26, documented R1 had an order for hospice to evaluate and treat on 4/24/26. This same document includes an order for Fentanyl (opioid pain medication) transdermal patch 25 MCG/HR (micrograms per hour) – apply 1 patch transdermally every 72 hours for pain with a start date of 4/27/26. On 5/5/26 at 11:55 AM, V2/DON stated staff were expected to perform hand hygiene before and after wound care, change gloves between contaminated and clean tasks and between wound sites, and avoid contamination of clean supplies. V2 confirmed failure to follow infection control practices during wound care could contribute to wound contamination and worsening infection. On 5/5/26 at 12:23 PM, V19/Wound Care Nurse Practitioner stated an alternating pressure mattress left in static mode would not provide alternating pressure relief and would contribute to increased pressure to wounds and pressure points. V19 further confirmed failure to perform hand hygiene, failure to change gloves, missed dressing changes, and cross-contamination during wound care could contribute to worsening wounds and infection. On 5/6/26 at 10:15 AM, V17/Wound Care Regional Director of Operations stated V19/Wound Care (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145774	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Havana	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 0686 Level of Harm - Actual harm Residents Affected - Few	Nurse Practitioner had previously voiced concerns regarding staff not completing dressing changes as ordered, failure to follow wound care recommendations, and staff competency concerns related to wound care practices. 2.On 5/4/26 at 8:30 AM, Resident R11 stated his bottom was very sore and felt like he may have a wound on his coccyx. R11's electronic medical record did not contain documentation related to redness, excoriation, skin impairment, or pressure ulcers to R11's coccyx area. On 5/4/26 at 12:54 PM, V4 (Certified Nursing Assistant/CNA) was observed providing peri-care to R11. R11 had an Enhanced Barrier Precaution (EBP) sign posted on the door; however, V4 was observed performing care without wearing a gown. During care, V4 turned R11 onto his side and R11's coccyx area was observed to be red and excoriated. R11 stated his bottom felt raw. V2 (Director of Nursing) entered the room during the observation and stated the area looked moisture associated. V2 confirmed Resident R11 required treatment to the coccyx area. V2 instructed V4 to remove the barrier cream from the coccyx area. V4 rubbed the cream off using a rag located in R11's room. R11 winced in pain and yelled ow. R11's top layer of skin was macerated, V2 stated R11's coccyx area appeared consistent with a Stage II pressure ulcer. R11's Braden assessment dated [DATE] documents R11 was assessed as high risk for skin breakdown. R11's electronic clinical record did not contain documentation of wound measurements, wound assessment, or treatment documentation for the coccyx ulcer identified on 5/4/26. On 5/6/26 at 10:13 AM, V17, Regional Director of Wound Care Operations, stated V19 Wound Nurse Practitioner had not been notified of R11's coccyx ulcer and indicated R11 would have been added to the wound list to be seen that day if notification had occurred. On 5/6/26 at 2:00 PM, V19 stated that R11's coccyx wound was a deep tissue injury and would likely worsen before it gets better. V19 stated the use of barrier cream by the facility for this wound only made it worse and V19 should have been notified soon to initiate an appropriate treatment. V19 stated the coccyx wound measures 15 centimeters by 15 centimeters, and she would be ordering Medi Honey (a medical grade honey product used for wound healing) and an adhesive foam bandage to be changed daily. V19 stated she will follow R11's wound care. 3. R12 was admitted on [DATE] with diagnoses of Pressure Ulcers, Osteomyelitis of Vertebra, Long Term use of Antibiotics, Arthritis due to Bacteria, Infectious Disease, Nightmare Disorder, Spinal Cord Injury, Sepsis and Type 2 Diabetes Mellitus. R12 was hospitalized on [DATE] with a diagnosis of Sepsis from left hip wound and surgical debridement of pressure wound was conducted, then returned to the facility on 4/27/26. R12 is cognitively intact. R12's Physician Orders dated 4/28/26 includes instruction for wound vac (Negative Pressure Wound Therapy/NPWT) to left hip at 125 mm/Hg (millimeters of Mercury) continuous/intermittent therapy, as well as dressing change orders. R12's current care plan documents R12 has a Pressure Ulcer to left hip, has a low loss air mattress and minimize pressure over boney prominences. The care plan had not been updated to include the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145774	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Havana	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 0686 Level of Harm - Actual harm Residents Affected - Few	use of or interventions for the Negative Pressure Wound Therapy (NPWT/wound vac). Upon entering R12's room on 5/5/26 at 11:00 AM, the NPWT/wound vac machine with drainage collection cannister was hanging from a pole, approximately 12 inches above R12's head, the machine was beeping an alarm sound and leak was displayed on the screen The Alternating Pressure Mattress control unit was lying under the bed, facedown and was alarming. R12 stated the machines were alarming since staff removed his breakfast tray although was unable to give a specific time. Staff Nurse was notified at 11:10 AM of the alarms. On 5/5/26 at 11:56 AM, V2 (Director of Nursing/Infection Preventionist) and V36 (Certified Nurse Aide, Scheduler/Medical Records Manager) entered R12's room. V2 stated I don't know why this (wound vac) is beeping. R12 was rolled to his side, and the wound vac dressing was not intact. V36 picked up the air mattress control unit off the floor, and the power failure light was flickering red. After turning the machine on and off and checking the cords, V36 identified the machine was not plugged in. During the wound vac dressing change, V2 was observed to remove the outside dressing with gloved hands, then reach to the bedside table and picked up a 250 ml (milliliter) bottle of saline, used the saline to moisten the dressing packed inside the wound, removed the soiled dressing and discarded it, went to the dresser across the room, picked up 2 packages of sterile gauze and scissors and placed on the bedside table, used a spray cleanser on the wound and wiped with non-sterile gauze and found more foam (type of material used to pack a wound) inside the wound, put spray bottle back on bedside table beside the 2 packages of sterile gauze and removed the foam dressing with the same pair of gloves donned throughout. After conducting hand hygiene and donning new non-sterile gloves, V2 picked up the spray cleaner again and cleansed the wound, opened the dressing change supplies and cut foam and outer covering of the dressing with scissors, coughed into the right arm of her gown (personal protective equipment used during wound care), completed the dressing change, pick up the two packages of sterile gauze and scissors from the bedside table and placed them back into the basin on the dresser with other clean supplies and did not cleanse the scissors or change gloves after wound care was conducted. On 5/5/26 at 1:30 PM, V1 (Administrator) stated V2 (Director of Nursing) is also the Infection Preventionist and Should set the standard for all staff. It sounds like (V2) contaminated the entire room. V1 agreed the wound vac and the air mattress should have been functioning and turned on. On 5/5/26 at 11:15 AM, V14 (Registered Nurse) stated a wound vac should be placed below the resident's wound and stated the machine may not be able to drain the contents of the tubing into the cannister adequately and backflow into the wound, especially if the machine has a leak error because suction is lost. V14 stated the only time an air mattress should be on static mode is during repositioning or if the resident requests it when sitting up to eat but should not be used for long periods of time.