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	06/05/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to prevent physical abuse for five residents in the Alzheimer's Unit (R2,R3,R4,R8 and R16). The facility also failed to put any interventions to prevent further abuse of residents by R1 in place to protect all 16 other residents in the Alzheimer's Unit (R2-R17). This failure leaves the potential for abuse for all 16 residents who reside in the Alzheimer's Unit.The Immediate Jeopardy began on 3/4/2026 at 7:30 PM when R1 first abused another resident and had no intervention in place to stop further abuse. While the Immediacy was removed on 6/3/2026 the facility remains out of compliance at a Level 2 while the the facility assesses the effectiveness of their plan of removal and Quality Assurance program. The facility's Abuse Prevention and Reporting policy dated 3/2026 documents Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. The facility's Abuse Prevention and Reporting policy dated 3/2026 documents a resident-to-resident altercation should be reviewed as a potential situation of abuse. Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. In addition, the facility shall take all steps necessary to ensure the safety of residents including, but not limited to, the separation of the residents. R1's Medical Record documents that he was admitted on [DATE] with diagnosis to include but not limited to Alzheimer's, Type II Diabetes Mellitus and Depression. R1's Medical Record documents that he is severely cognitively impaired and does not always answer questions appropriately. R1's Medical Record does not contain any interventions put in place to prevent him from continuing to abuse residents in the Alzheimer's Unit.On 6/2/2026 and 6/3/2026 in the mornings R1 was pleasant and able to answer questions about his family to include names, relationships, where he was and time of day. On 6/2/2026 and 6/3/2026 in early afternoons/directly after lunch R1 refused to speak to surveyor, became agitated when spoken to and stated Shut up b*tch. The facility's Final Abuse Investigation dated 3/10/26 documents that on 3/4/2026 R1 purposefully ran into R16's legs with his walker. R1's Psychiatry Note dated 3/13/26 documents R1 was being seen for episodic agitation and staff reported intense behaviors such as pulling out his catheter, pushing his walker into another resident and knocking another resident down. The facility's Final Abuse Investigation dated 4/20/26 for incident on 4/15/2026 includes a written and signed statement by V11 (Certified Nurse Aide) documenting that she saw R1 strike R4. R1's Psychiatry Note dated 4/17/2026 documents (R1) recently hit his roommate in the head unprompted, threw and broke his TV and gets 'very physically aggressive.' The facility's Final Abuse Investigation dated 4/19/2026 documents that on 4/19/2026 R1 swung at R3 and did not make contact, then R3 swung and connected with R1's face. R1's Psychiatry Note dated 5/11/2026 documents R1's clinical course is marked by significant physical and verbal aggression, including instances of hitting his roommate, (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	punching a nurse in the jaw, and throwing his television across the room. These high risk behaviors necessitated 1:1 supervision. The prioritized treatment plan focuses on stabilizing his aggressive behaviors through medication titration. R1's Psychiatry notes dated 5/22/26 document due to ongoing impulsive behaviors and need for increased supervision, the resident was recently moved closer to the dayroom. The facility could not produce any documentation of increased supervision of R1 at any time.The facility's Final Abuse Investigation dated 4/26/2026 documents that on 4/21/2026 R1 purposefully ran his walker into R2's walker pushing her walker into her stomach and causing her to slam into a wall. The facility's Preliminary 24-hour Abuse Investigation Report dated 5/28/2026 includes a written and signed statement by V12 (Certified Nurse Aide) that documents V12 (CNA) heard yelling and went into R1's room to find R1 moving his walker up and down as if he might have bumped (R8) with it. On 6/2/26 V5 (Certified Nurse Aide) stated that R1 is very aggressive and random. You never know what will set him off. On 6/2/26 V6 (Certified Nurse Aide) stated she had witnessed a couple of the abuse incidents between R1 and other residents. He(R1) just gets so mad. He gets mad at us too, he has punched a nurse in the jaw, kicked a CNA in the stomach and he ripped his TV off the mounting in his room. It doesn't matter if it is a resident or a staff member, if he is mad and you are close he will get you. R1's current care plan dated 3/20/2026 does not include any documentation of R1 hitting or being mean to any other residents. R1's current care plan does not include any interventions after any of R1's incidents on 3/4/26,4/15/26,4/19/26,4/21/2026 and 5/28/2026. On 6/3/2026 at 9:00 AM V1 (Administrator in Training) confirmed that R1 had multiple instances of founded abuse towards other residents with no new interventions put in place to prevent further abuse of other residents.On 06/03/2026 at 11:39 AM the facility presented an abatement plan On 06/03/2026 at 12:28 PM the facility presented an amended abatement plan On 06/03/2026 at 2:04 PM Regional Office requested more information from the facility On 06/03/2026 at 3:22 PM the facility presented an amended abatement plan On 06/03/2026 at 4:16 PM Regional Office requested more information from the facility On 06/03/2026 at 4:41 PM the facility requested more information from the facility On 06/03/2026 at 4:48 PM the facility's abatement plan was accepted by Regional Office. On 06/05/2026 the surveyor confirmed through observation, interview and record review the facility took the following steps to stop the Immediate Jeopardy: All 16 residents on the dementia unit's care plan were reviewed and interventions were implemented as needed on 6/3/26 by V13 (Social Services Director) and V14 (Regional Social Services). All 16 residents on the dementia unit were assessed for abuse/neglect by V13 (Social Services Director) and V14 (Regional Social Services.) R1 was placed on 1:1 immediately on 6/3/2026 in utmost abundance of caution for 48 hours. Skin assessment done by V15 (Corporate Infection Preventionist), aggressive behavior screening done by V14 (Regional Social Services) V3 (Regional Nurse Consultant),V1 (Administrator in Training), V13 (Social Services Director), V14 (Corporate Social Services),V15 (Corporate Infection Preventionist) V16 (Regional Director of Operations) and V17 (Psychiatrist) comprehensive care plan and behavior review to determine further care needs on 6/3/26 R1 was moved closer to the nurse's desk on 5/17/2026 Slide lock added on R1's adjoining bathroom to prevent R8 from entering R1's room; completed by V18 (Maintenance Director). On 6/3/26 V14 (Regional Social Services) reviewed R1's care plan and additional interventions were added to prevent physical aggression towards others including Attempt to mitigate triggering events: neighbor entering room uninvited, others rummaging in room, place stop sign on inside of resident's bathroom door to deter neighbor from entering room through adjoining restroom, Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed, Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes, Monitor for signs of impending aggression (ex - balling fists, raising voice, abrupt actions). When noted, provide redirection/assist to alternative location with lower stimulation, Provide a program of activities that is of interest and accommodates residents status. V3 (Regional Nurse Consultant) V16 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	(Regional Director of Operations) V1 (Administrator in training) and V13 (Director of Social Service and Activities) held a conference call with V17 (Psychiatrist) related to R1's history of abuse allegations on 6/3/26. Additional interventions were discussed and added to R1's care plan to include 1:1 activity programing and social service director to increase pop-in visits. Also discussed appropriate specialized alternate placement if interventions continue to be unsuccessful. All facility staff were re-in serviced on the facility abuse policy by V1 (Administrator in Training) and V16 (Regional Director of Operations) 6-3-2026. Skin checks were completed on all residents residing in the facility on 6-3-26 by V15 (Corporate Infection Preventionist). IDT including Administrator educated on facility Abuse Policy by V16 (Regional Director of Operations) on 6-3-26. IDT (Intra disciplinary Team) educated on facility comprehensive care plan policy on 6-3-26 by V3 (Regional Nurse Consultant). IDT educated on facility Behavioral Health Services Program policy on 6-3-26 by V13 (Director of Social Service) and V14 (Regional Social Services)Abuse/neglect added to facility morning meeting tracking log on 6-3-26 by V16 (RDO) Behavior added to facility morning meeting tracking log on 6-3-26 by V16 (RDO)V10 (Vice President of Clinical Services) reviewed facility Abuse policy and updates completed on 6-3-26. Ad Hoc QA completed on 6-3-26 with the IDT regarding alleged non-compliance. Audit findings, identified concerns, corrective actions, and compliance trends will be reviewed weekly through the facility QA process to ensure continued compliance and determine the need for ongoing monitoring by IDT. Any identified concerns during the audit process will result in immediate re-education and corrective action by V1 (Administrator in Training).