STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146050	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven of Arcola	422 East Fourth Street Arcola, IL 61910

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 42702 Based on interview and record review the facility failed to operationalize their abuse prevention policy by failing to document identified interventions for five (R2, R3, R4, R5 and R6) of nine residents reviewed for abuse from a total sample list of nine residents reviewed. Findings include: The facility provided Abuse Prevention Program Policy dated 11/28/16 documents that the facility affirms the right of residents to be free from abuse, neglect, misappropriation of resident property, and exploitation. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect or abuse of our residents. This will be done by implementing systems to investigate all reports and allegations of mistreatment, exploitation, neglect, abuse of residents and misappropriation of resident property by promptly and aggressively making the necessary changes to prevent future occurrences. Through the care planning process, staff will identify any problems, goals and approaches,which would reduce the changes of mistreatment, neglect and abuse of residents. R2, R3, R4, R5 and R6's medical records do not document interventions to address issues regarding behaviors with other residents. On 8/7/24 at 9:42AM, V1 Administrator said that the identified intervention after the 7/16/24 (resident to resident abuse) allegation involving R2 and R6 was to keep them separated and to prevent R2 from asking residents for hugs. V1 confirmed that these interventions were not documented. On 8/7/24 at 9:43AM, V1 Administrator said that intervention after the 7/16/24 (staff to resident abuse) allegation involving R3 was to remove the snack cart from reach without assistance. V1 confirmed that this intervention was not documented. On 8/7/24 at 9:44AM, V1 Administrator said that the intervention after the 7/15/24 (resident to resident abuse) allegation involving R4 and R5 was to place the activity cart in a less crowded area so that wheel chairs and ambulatory residents didn't bump into one another. V1 confirmed that this intervention was not documented. On 8/7/24 at 9:45AM, V1 Administrator said that all interventions identified during the investigations should have been documented in the residents medical record/care plan to ensure that all staff are aware of and implement these interventions to prevent further incidents.

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