

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2024
NAME OF PROVIDER OR SUPPLIER The Haven of Arcola		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to protect a resident's (R2) right to be free from abuse by another resident (R1). This failure affects three (R1, R2, R3) of seven residents reviewed for abuse in the sample list of seven. Findings include: The facility's Final Report dated 8/15/24 documents on 8/8/24 at 8:25 AM staff serving breakfast witnessed R2 grab R1's oatmeal and R1 hit R2 on the right side of R2's face with an open hand. R1 and R2 were immediately separated and there was no injury or redness noted. The investigative file for this incident included interviews with R3, V6 Certified Nursing Assistant (CNA) and V7 CNA that document they witnessed this incident and confirmed R2 grabbed R1's oatmeal and then R1 open handed smacked R2's face/head. R1's Minimum Data Set (MDS) dated [DATE] documents R1 has severe cognitive impairment and - BIMS 7, other behaviors occurred 1-3 days during review period. R2's MDS dated [DATE] documents R2 has short and long term memory loss. R2's Skin Evaluation dated 8/8/24 documents R2 was slapped on the face by another resident and there was no redness or injury. On 8/20/24 at 9:12 AM attempts were made to interview R2. R2 was confused and unable to give details regarding the incident with R1. On 8/20/24 at 9:17 AM R1 stated R1 vaguely recalled hitting a man a few weeks ago, and thought the man had been harassing a woman. R1 was unable to give any additional details regarding the incident with R2. On 8/20/24 at 9:39 AM R3 stated R3 was sitting at the table with R1 and R2 when the incident occurred. R3 stated R2 had taken R3's milk and spilled it on himself and the table, and then R2 grabbed R1's oatmeal. R3 stated R1 then slapped R2. R3 stated R1 hasn't done anything like that before, but R1 has a temper. (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 - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24 at 1:34 PM V7 CNA stated the R1's/R2's incident occurred during breakfast, R1 and R2 were sitting at the same table next to each other. V7 stated R2 grabbed R1's oatmeal and then R1 smacked R2 in the head with an open palm. V7 stated R1's actions were intentional and not an accident. V7 stated R2 has a history of grabbing other residents' food and drinks, and now R1 and R2 have to be seated at separate tables and supervised. On 8/8/24 at 1:42 PM V6 CNA stated on 8/8/24 during breakfast V6 heard a commotion at R1's/R2's table. V6 turned around to see oatmeal fly off the table onto the floor and R1 then hit R2 with an open palm above R2's right ear/side of head. V6 stated R1's actions were intentional and afterwards R1 seemed to know what R1 did was wrong. V6 stated R2 has a history of trying to take other resident's food/drinks, and staff would try to redirect R2 and provide more food/drinks. V6 stated now R1 and R2 no longer sit next to each other, and R2 sits at a table away from others to avoid R2 grabbing other resident's food/drinks. The facility's Abuse Prevention Policy dated 11/28/16 documents the facility affirms the residents' right to be free from abuse which includes physical abuse. This policy documents abuse includes a willful injection of injury and willful, when used in defining abuse, means the action was deliberate and not that the action was intended to cause harm or injury.		

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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** 40385 Based on interview and record review the facility failed to report an allegation of abuse to the administrator. This failure affects two (R2, R3) of seven residents reviewed for abuse in the sample list of seven. Findings include: On 8/20/24 at 9:39 AM R3 stated around a few weeks to a month ago R2 came into R3's room, R3 told R2 to leave R3's room which may have set (R2) off. R3 stated R2 then grabbed R3's wrist and R3 felt afraid of R2. R3 stated R3 staff responded to R3's call light and directed R2 out of R3's room, and R3 told V8 Certified Nursing Assistant (CNA) that R2 had grabbed R3's wrist. R3's Minimum Data Set, dated dated dated [DATE] documents R3 is cognitively intact. R2's MDS dated [DATE] documents R2 has short and long term memory loss and wandered one to three days during the seven day lookback period. On 8/20/24 at 9:53 AM V8 CNA stated a few weeks ago R2 was lying in R3's bed while R3 was in the room, and staff had to redirect R2 out of the room. V8 denied being told that R2 grabbed R3. On 8/20/24 at 10:55 AM V3 CNA stated awhile ago, R2 was in R3's room and staff had to redirect R2 out of the room. V3 stated R3 said that R2 grabbed R3's arm, but V3 did not witness this. V3 stated V3 reported R3's allegation to a nurse, but could not recall which nurse. On 8/20/24 at 9:57 AM V1 Administrator stated V1 did not have any abuse allegations involving R2 and R3. At this time R3's allegation was reported to V1. On 8/20/24 at 1:22 PM V1 stated staff are expected to immediately report abuse allegations to V1. V1 confirmed R3's allegation that R2 grabbed R3's wrist should have been reported to V1. The facility's Abuse Prevention Program dated 11/28/16 documents Employees are required to immediately report any occurrences of potential/alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administrator.		