

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

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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 02/07/2025
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** 41970 Based on interview and record review the facility failed to protect the resident's right to be free from verbal abuse by another resident. This failure affects two of four residents (R2 and R7) reviewed for abuse in a sample list of eight residents. Findings include: The facility undated policy titled Abuse Prevention Policy documents abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish to a resident. The term willful in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict harm or injury. Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individuals' age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again. 1. R2's undated Face Sheet documents medical diagnoses of Depression, Bipolar Disorder, Traumatic Brain Injury, Heart Failure, Prosthetic Heart Valve, Atrial Fibrillation and Cardiac Pacemaker. R2's Minimum Data Set (MDS) dated [DATE] documents R2 as cognitively intact. R1's Minimum Data Set (MDS) dated [DATE] documents R1 as cognitively intact. This same MDS documents R1 requires set up assistance for eating, dressing, toileting, oral hygiene, bathing and is independent in bed mobility and transfers. This same MDS documents R1 was able to walk 150 feet independently. R2's Final Report to State Agency dated 12/26/24 documents on 12/21/24 at 12:00 PM R1 was yelling out in the dining room. This same report documents (R1) began cussing and yelling in the dining room stating 'I'm going to kill all of you. (R2) stated she didn't know why (R1) was upset but that they (R1, R2) exchanged words. In conclusion, it was determined that the resident to resident (R1, R2) altercation did occur however, neither resident sustained any injuries. (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

FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 146050	If continuation sheet Page 1 of 5
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/25 at 11:40 AM R2 stated R1 was mean to everyone. R2 stated R1 would yell and cuss and scare R2 and other residents. R2 stated R1 told R2 that he was going to kill her and then tried to throw a walker at another (unknown) resident so R2 got up and tapped R1 on the shoulder to remind R2 that he cannot act like that. R2 stated (R1) was cussing and scaring me and all the residents and the staff. (R1) should not act like that. (R1) was supposed to be nice. (R1) was not nice to anyone. On 2/6/25 at 11:30 AM V10 Licensed Practical Nurse (LPN) stated V10 sent R1 to the emergency roiaognom on [DATE] after an 'extreme outburst' in the dining room. V10 LPN stated the dining room was full of residents and a few staff and R1 was in the dining room threatening to kill everyone. V10 LPN stated R1 yelled at R2 I am going to kill you! V10 LPN stated R1 picked up his walker in his rage and almost hit another (unknown) resident in the head so R2 got up and said you mess with my friends, you mess with me and then R2 patted R1 twice in the shoulder/neck area. V10 stated (R1) was out of control that day. I don't know why (R1) was allowed to come back after that. V10 stated R1 was a very tall, large man who could easily cause damage to anyone around him. On 2/6/25 at 2:40 PM V1 Administrator stated R1 was mad on 12/21/24 due to R1 missed his snack pass and was not allowed to receive a snack. V1 Administrator stated R1's anger was directed towards R2. V1 Administrator stated R1 should have been given a snack if he asked for one so that may have appeased him and prevented R1's outburst. On 2/6/25 at 3:10 PM V14 Licensed Practical Nurse (LPN) stated It was supper time on 12/23/24 and the dining room was full of residents eating their supper. (R1) was mad because he couldn't have his bedtime medications early. I was standing behind my medication cart in the dining room at this time. (R1) became aggressive, demanding and violent. (R1) was gritting his teeth, his face and hands were shaking because he was so mad and he started lifting up his walker a foot off of the ground and pounding it on the floor multiple times. I repositioned my medication cart at an angle so if (R1) tried to throw his walker at me it might hit the medication cart first. All of the residents in the dining room were a witness to (R1's) behaviors. (R1) was yelling and cursing saying 'F*** (expletive) you! I am going to kill you while looking directly at (R2) and everyone in here and then kill myself'. I was so worried (R1) would hurt one of the residents. (R1) was out of control again. (R2) was sitting in a chair within a few feet of (R1) so I motioned for (R2) to move out of the way. (R2) was so scared, her face was white as a ghost. I talked to (R2) later and she said she was very scared and thanked me for keeping her safe. On 2/7/25 at 1:35 PM V1 Administrator stated she had heard R1 was upset about not being able to get his medications early but did not realize R1's outburst was in front of any other residents or was directed at R2. V1 Administrator stated after her investigating this incident on 2/7/24 R1 did in fact yell and curse at R2. 2. R7's undated Face Sheet documents medical diagnoses of Schizophrenia, Bipolar Disorder, Atrial Fibrillation, Ischemic Cardiomyopathy, Heart Failure and Chronic Kidney Disease. R7's Minimum Data Set (MDS) documents R7 as cognitively intact. R7's Nurse Progress Notes does not document an altercation with R1 on 12/21/24. R8's Minimum Data Set (MDS) dated [DATE] documents R8 as cognitively intact. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Minimum Data Set (MDS) dated [DATE] documents R1 as cognitively intact. This same MDS documents R1 requires set up assistance for eating, dressing, toileting, oral hygiene, bathing and is independent in bed mobility and transfers. This same MDS documents R1 as able to walk 150 feet independently. On 2/6/25 at 2:15 PM R8 stated R8 witnessed R1 yell at R7 on 12/21/24 just before lunch time in the facility community resident room on the South Unit. R8 stated R7 was sitting in a recliner chair when R1 approached R7 and yelled at R7 to get the f*** (expletive) out of my chair or else! On 2/6/25 at 4:30 PM R7 stated R1 yelled at him one day when R7 was sitting in the recliner chair in the community dayroom. R7 stated R1 yelled get the f*** (expletive) out of my chair or else! R7 stated R1 was'real mad at R7 for sitting in the recliner. R7 stated It scared me a little but (R1) is always yelling and carrying on. I think (R1) would kick my a** (expletive) since he is so big but you know what they say the bigger they are, the harder they fall. I'm not sure if I could do it but I'd sure give a try. On 2/7/24 at 1:40 PM V1 Administrator stated V1 was not aware that R1 yelled and cursed at R7 on 12/21/24. V1 Administrator stated R1 had a behavioral outburst in the dining room on 12/21/24 and after talking with V13 Social Service Assistant (SSA) found out that this incident between R1 and R7 had occurred just prior to R1's dining room incident. V1 Administrator stated after interviewing residents and staff on 2/7/24 it was determined that R1 did yell and curse at R7 in the community dayroom on 12/21/24. V1 Administrator stated V1 will be doing some educational inservicing on Abuse with her staff.		

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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** 41970 Based on interview and record review the facility failed to report allegations of verbal abuse to the Abuse Coordinator for three of four residents (R1, R2, R7) reviewed for abuse in a sample list of eight residents. Findings include: The facility undated policy titled Abuse Prevention Policy documents Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer. In the absence of the administrator, reporting can be made to an individual who has been designated to act in the administrator's absence. 1. R2's Minimum Data Set (MDS) dated [DATE] documents R2 as cognitively intact. The facility was unable to provide documentation a resident (R2) to resident (R1) verbal altercation on 12/23/24 was reported to the Abuse Coordinator. On 2/6/25 at 11:40 AM R2 stated R1 was mean to everyone. R2 stated R1 would yell and cuss and scare R2 and other residents. R2 stated (R1) yelled at me and it scared me. (V14 Licensed Practical Nurse) was there to help me get away from (R1). On 2/6/25 at 3:10 PM V14 Licensed Practical Nurse (LPN) stated R1 became aggressive, demanding and violent during supper on 12/23/24. V14 stated (R1) was yelling and cursing saying F*** (expletive) you! I am going to kill you (while looking at (R2)) and everyone in here and then kill myself. I talked to (R2) later and she said she was very scared and thanked me for keeping her safe. On 2/6/25 at 3:30 PM V14 Licensed Practical Nurse (LPN) stated V14 should have reported R1 verbally abusing and threatening multiple residents including R2 individually on 12/23/24. V14 LPN stated Word gets around quick here. I thought (V1) would have known about it. But, I should have told (V1) anyway. 2. R7's Minimum Data Set (MDS) documents R7 as cognitively intact. The facility was unable to provide documentation a resident (R1) to resident (R7) verbal altercation on 12/21/24 was reported to the State Agency. On 2/6/24 at 1:00 PM V13 Social Service Assistant (SSA) stated V13 stated she obtained R8's witness statement on 12/23/24 from the 12/21/24 incident between R1 and R2 but didn't think of it as a separate incident. V13 stated R8 told her that R1 and R7 got into it on 12/21/24 but thought it would have been investigated with all of the other things that happened that day with R1. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/25 at 4:30 PM R7 stated R1 yelled at him one day when R7 was sitting in the recliner chair in the community dayroom. R7 stated R1 yelled get the f*** (expletive) out of my chair or else! R7 stated R1 was real mad at R7 for sitting in the recliner. R7 stated It scared me a little but (R1) is always yelling and carrying on. I think (R1) would kick my a** (expletive) since he is so big but you know what they say the bigger they are, the harder they fall. I'm not sure if I could do it but I'd sure give a try. On 2/7/25 at 12:15 PM V1 Administrator stated staff should always report any allegation of abuse to V1 Administrator. V1 Administrator stated the staff did not follow the facility abuse policy by not reporting R1's verbal statements to R7 on 12/21/24 and R2 on 12/23/24.		