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	08/10/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure resident dignity for three of three residents (R4, R5, R6) reviewed for dignity in a sample list of seven residents.R4's Minimum Data Set (MDS) dated [DATE] documents R4 as cognitively intact. This same MDS documents R4 requires supervision with eating, oral hygiene, toileting, bathing, dressing, personal hygiene and bed mobility. R4's Care plan documents medical diagnoses as Thoracic Scoliosis, Depression, Neuropathy, Thrombophlebitis of Lower Extremities, Unsteady on Feet, Muscle Wasting and Atrophy and Major Depressive disorder. This same care plan initiated 11/8/24 does not document a focus area, goal nor interventions for R4's behaviors of consensual sexual behavior with male peers prior to 7/29/25. This same care plan documents R4 requires a wheelchair for mobility. R5's Minimum Data Set (MDS) dated [DATE] documents R5 as cognitively intact. R6's Minimum Data Set (MDS) dated [DATE] documents R6 as cognitively intact. R4 and R5's shared Final Report to the State Agency dated 8/1/25 documents R4 stated R5 started rubbing her upper leg then moved up to touch her perineal area while she was sitting in the day room. This same report documents R4 moved away from R5 and that R5 did not actually touch R4's perineal area. R4's written statement dated 7/29/25 documents (R4) was sitting next to the ping pong table. (R5) got up off the couch and came towards me. (R5) was standing and bent down and started rubbing my leg. (R5) started at the knee moving up towards my (points to vagina). I backed away from (R5) and went to my room. I don't know what (R5) was thinking. On 8/9/25 at 12:10 PM V7 Licensed Practical Nurse (LPN) stated R5 touched R4 inappropriately in the hall next to the dayroom on the South unit on 7/29/25. V7 LPN stated R5 walked up to R4 who requires a wheelchair and touched R4's upper thigh and then moved his hand farther towards R4's genital area then R4 wheeled herself back away from R5. V7 LPN stated R4 told V7 that ‘(R5) touched my leg and tried to reach my vagina. I didn't like that.' V7 LPN stated R5 was sent to the emergency room for evaluation due to his behaviors. On 8/9/25 at 2:55 PM R6 stated R4 was sitting in the resident lounge in her wheelchair when R5 got up off of the couch (in the same room) and walked over to R4. R6 stated R5 put his hand on the inside of R4's lower thigh/knee area and squeezed lightly and then left his hand there for a few minutes. R6 stated R5 then moved his hand ‘clear up there' (R6 motioned to his perineal area). R6 stated he couldn't believe what he was seeing. R6 stated he was in shock. R6 stated he saw R4 move her wheelchair back away from R5. R6 stated he did not think R5 made contact with R4's perineal area but that ‘it wasn't for lack of trying.' On 8/10/25 at 10:00 AM V1 Administrator stated R4 and R5 both reside on a locked psychiatric unit. V1 Administrator stated both R4 and R5 are cognitively intact yet unable to make decisions for themselves and require constant supervision. V1 Administrator stated she thinks this incident is more of a resident rights issue than abuse due to R5 did not make contact with R4's perineal area. The facility policy titled Resident Rights Guideline revised October 2023 documents residents have the right to be treated with dignity and respect.

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
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(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 - 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. (continued on next page)

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(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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect the resident's right to be free from physical abuse by another resident with known physical behaviors for two of four residents (R1, R2) reviewed for abuse in the sample list of seven residents. This failure resulted in R2 experiencing physical trauma including a lacerated lip, swollen eye, and multiple scratches, and fear of R1 causing R2 to refuse emergency services due to fear of R1 attacking R2 in the hospital after R1 punched R2 multiple times. This past non-compliance occurred from 7/18/25-7/25/25.R2's Electronic Medical Record (EMR) documents medical diagnoses as Schizoaffective Disorder, Paranoid Personality Disorder, Dementia with Agitation, Extra Pyramidal and movement disorder and Paranoid Schizophrenia. R2's Minimum Data Set (MDS) dated [DATE] documents R2 as cognitively intact. This same MDS documents R2 requires supervision for eating, oral hygiene, toileting, bathing, dressing, personal hygiene, bed mobility, transfers and walking up to 150 feet. R2's Nurse Progress Note dated 7/19/25 at 12:13 AM documents V4 Licensed Practical Nurse (LPN) was in R2's room administering medication to R2's roommate and noted R2 was laying in his bed laughing uncontrollably just prior to this incident. This same note documents A short time later, (R1) heard (R2's) laughter and entered (R2's) room. (R1) was verbally and physically aggressive. This same note documents (V5) Activity Assistant (AA) separated R1 and R2 and then R1 was assisted to R1's room across the hall. This same note states R2 stated R1 yelled at him to stop laughing. This same note documents R1 approached R2's bed where he was laying and hit R2 several times on the head. This same note documents R2 obtained a cut on his top lip and refused to go to the emergency room for medical care. R1's Minimum Data Set (MDS) dated [DATE] documents R1 as cognitively intact. This same MDS documents R1 requires supervision for eating, oral hygiene, toileting, bathing, dressing, personal hygiene, bed mobility, transfers and walking up to 150 feet. R1's Nurse Progress Note dated 7/19/25 documents R1 was walking down the hallway towards his room, as R1 got closer to his room R1's verbally aggressive behavior became louder, then R1 dropped his linens that he was carrying for his shower and R1 entered R2's room. This same note documents (V4) LPN yelled and said NO do not go in there. (V5) Activity Assistant (AA) separated (R1, R2). (V5) AA took (R1) to his room across the hall. (R1) had a bloody nose. When the staff asked what happened (R1) stated (R2) was laughing and (R1) believed that (R2) was laughing at him. R6's Minimum Data Set (MDS) dated [DATE] documents R6 as cognitively intact.R1 and R2's shared Final Incident Report to the State Agency dated 7/24/25 documents R1 believed R2 was laughing at him and entered R2's room where a physical altercation occurred. This same report documents staff were able to break up the altercation. This same report documents R2 obtained a cut to his upper lip and R1 was noted to have a bloody nose. On 8/9/25 at 9:45 AM R2 stated he was relaxing in his bed the night of 7/18/25 when R1 'came storming in my room and beat me up.' R2 stated he did not know why R1 was so mad. R2 stated R1 punched R2 with closed fists in the head, arms and face and repeatedly yelled 'Shut the f*** (expletive) up.' R2 stated he put his arms over his face in order to defend and protect himself. R2 stated R1 pulled him out of his bed onto the floor and continued to hit R2. R2 stated V5 Activity Assistant (AA) entered R2's room and had to 'pull' R1 off of R2. R2 stated I was so frightened that night. I didn't want to leave the room. I didn't want to go to the hospital because that is where (R1) was going. I just stayed in my room because I was afraid. It really hurt when (R1) was punching me. (R1) beat me up one other time on the smoking patio a long time ago. R2 stated V5 AA stayed with R1 until the police arrived to protect R2 from R1 in case R1 came back in R2's room.On 8/9/25 at 2:50 PM R6 stated he witnessed R1 hitting R2. R6 stated R2 was his roommate at the time and he never had any 'trouble' with R2. R6 stated R1 has a bad temper and stays away from R1 as much as possible. R6 stated he was sitting on his bed by the window when R1 'marched' into his room and started punching R2. R6 stated R2 was just laying in his bed and did not provoke R1. R6 stated he felt shocked that anyone would come into his room and just start beating someone up and felt scared of R1. R6 stated he was glad 'they' took R1 away so that R6 didn't have to worry about R1 returning to his room to 'get' R2. On 8/9/25 at 11:30 AM V2 Director of Nurses (DON) confirmed R1 walked into R2's room on 7/18/25 without provocation and hit and punched R2. V2 DON stated R2 has a behavior of laughing hysterically and believes that R1 thought R2 was laughing at R1. V2 DON stated the staff immediately responded when they heard the screaming and yelling coming from R2's room. On 8/9/25 at 1:15 PM V4 LPN stated the evening of 7/18/25 around 8:30-9:00 PM R1 was walking down the hall heading towards his room. V4 LPN stated R1 was carrying his