

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

Printed: 07/18/2026
Form Approved OMB
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 11/18/2025
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 - Some	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 protect the resident's right to be free from physical and sexual abuse by other residents. The failure affects four of four residents (R2, R3, R4, R5) reviewed for abuse on a sample list of seven. Findings include: 1.) The facility's Final Incident Report dated 9/4/25 at 8:35AM sent to Illinois Department of Public Health reported an incident involving R4 and R5. The report states R4 was observed by staff on 8/30/25 at 3:50 PM touching R5 breast. R4's Medical Record documents R4 has diagnoses of schizoaffective disorder and cardiorespiratory condition. R4's Minimum Data Set (MDS) dated [DATE] documents R4 is cognitively intact and ambulatory with supervision. R4's care plan dated 11/13/25 documents R4's behaviors of being aggressive and making inappropriate statements to others. R5's Medical Record documents R5 has diagnoses of Severe Dementia without Behaviors, Major Depressive Disorder and Dysphagia Oral Phase. R5's MDS dated [DATE] documents R5 is severely impaired cognitively and ambulatory with supervision. R5's Care Plan dated 11/13/25 documents R5 exhibits behavior difficulties which include restlessness, anxiety, agitation, pacing and wandering. V16, CNA (Certified Nursing Aide) stated in interview on 11/18/25 at 2:23 pm, Yes, I did witness the incident with (R4) and (R5). I was coming around the corner and (R5) was standing at the first table in the dining room and (R4) was standing behind (R5) and was squeezing (R5's) left breast. (R5) was just standing there. (R4) was separated from (R5) and (R4) stated 'Leave me alone it makes me (aroused) squeezing her breast.' Yes, (R4) knew what he was doing. V17, CNA stated on 11/18/25 at 2:27PM I did not witness the incident between (R4) and (R5) but couple of days before the incident I was taking (R4's) vital signs and (R4) stated to me 'Let me see your (breasts).' I reported the incident to the charge nurse that night. V1, Administrator stated on 11/18/25 at 3:00 PM, Due to the incident we moved R5 to the (other unit). 2.) The facility's State of Illinois Illinois Department of Public Health Long-Term Care Facility & IID -Serious Injury Incident Report dated 10/23/25 at 4:10 PM documents on 10/16/25 at 2:20 PM R2 open handed smacked R3 on R3's right upper arm. R2 stated R2 acted in retaliation claiming that R3 hit R2 first, however witnesses did not support that R3 hit R2. V8 Certified Nursing Assistant's (CNA) written Witness Statement dated 10/16/25 documents V8 was coming out of the CNA room and R3 grabbed onto the armrest of R2's wheelchair and R2 started (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 - Some	smacking R3's arm. V8 immediately separated R2 and R3. The typed interview with R2 dated 10/16/25 documents the incident occurred on R2's hallway a little past R2's doorway. The interview documents R2 saw R3 coming down the hallway and as they passed each other R3 smacked R2 on the hand, so R2 smacked R3 back. R2's Minimum Data Set (MDS) dated [DATE] documents R2 as cognitively intact. R2's active Care Plan documents a problem dated 9/26/25 R2 that R2 is suspicious and paranoid of others entering her room without permission. This care plan includes a problem dated 2/11/25 that R2 has behaviors related to bipolar disorder, becomes anxious with agitation, has verbal outbursts, yelling and demanding of others, makes hateful/inappropriate comments, and mocking others. R3's MDS dated [DATE] documents R3 has short and long term memory impairment and is moderately impaired with cognitive skills for daily decision making. R3's active Care Plan documents R3's diagnoses include Dementia and Paranoid Schizophrenia, and a problem dated 7/25/25 that R3 wanders the hallways, violates the personal space of others, does not comprehend social limits and may be combative with staff. On 11/17/25 at 1:10 PM R2 was in her wheelchair in her room. There was a mesh barrier across R2's doorway with a stop sign that said, Do Not Enter. R2 stated R3 gets in people's rooms and sleeps in their beds and the facility hasn't done much about it. R2 stated there was one time that R3 got physical with R2 on an unidentified date. R3 tried to go into R2's room, R3 banged on my (R2's) arm, so I (R2) banged her (R3) back in the arm. On 11/17/25 at 9:36 AM R3 was sitting in the recliner in R3's room. R3 responded to name only but did not respond to any questions. On 11/17/25 at 1:27 PM V8 CNA confirmed V8 witnessed R2's/R3's altercation on 10/16/25. V8 stated the following: The incident happened between 2:00 PM and 2:30 PM. V8 witnessed R2 coming down the hallway from R2's room towards the nurse's station. R2 was in the middle of the hallway and R3 came up behind R2. R2 does not like people R2's personal space and R3 wanders and likes to go into other resident rooms and lay in their beds. R2 may have thought R3 was in R2's room. As R3 wheeled passed on the right side of R2, between the railing and R2, R3 grabbed the arm rest of R2's wheelchair to propel herself. R2 got upset, yelled at R3 and slapped R3 in the right hand three times reprimanding R3 like you would a child. R2's hit was intentional. R3 did not seem fazed or affected by R2. V8 told R2 that R2 should have waited since V8 was coming to assist R2. R2 swears that R3 hit R2 first, but V8 did not see R3 hit R2. V8 stated R3 may have accidentally bumped R2 when R3 grabbed R2's arm rest. R2 is with it, knows staff, and is alert/oriented to person, place, time and situation. R3 is confused and in her (R3's) own world.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide a 30-day notice for an involuntary discharge for one of one resident (R1) reviewed for involuntary discharge in the sample list of seven. Findings include The facility's Immediate/Emergency Transfer and Discharge Policy dated September 2016 states To assure resident transfers and discharges will be conducted in accordance with residents' rights, physician's orders, and in such a manner as to maintain continuity of care for the resident. The Physician Order Sheet dated November 2025 documents R1 has the following diagnoses: Schizoaffective Disorder, Varicella without complications and Drug Induced Subacute Dyskinesia. R1's Minimum Data Set (MDS) assessment dated [DATE] documents, BImS (Brief Interview for Mental Status) of 15, cognitively intact. The Facility Incident Report Final Report dated 11/15/25 documents R1 exited the building on 11/10/25 at 5:10 AM through the Southwest exit door and was found in a field about three blocks from the facility at 6:15 am. EMS arrived and transported R1 to the Emergency Department at the local hospital where R1 was diagnosed with hypothermia. The Progress Note dated 11/12/25 at 5:15 PM documents V9, Social Service Designee and V1 Administrator delivered involuntary discharge papers to R1 while at the hospital. V24, Brother of R1 stated on 11/15/25 at 10:52 AM Yes I am the half brother of (R1) and (R1) can barely talk he has a speech problem. I asked him what happened and he won't tell me anything. I would call the facility and talk with him on the phone, and (R1) has been at the same facility for over 20 years. V1, Administrator stated in interview on 11/15/25 at 2:30 PM, Yes (R1) was delivered involuntary discharge papers because we are not a locked unit and (R1) needs locked doors to keep him from exiting on his own. I told the hospital the facility would take him back as a resident if they would adjust his medication so (R1) would not want to leave the building. The facility does not have locked exit doors and this is how (R1) was able to leave the building, through the southwest exit door. V20, Director of Care Services for the local hospital stated in interview on 11/18/25 at 9:30 AM The facility served (R1) papers for an involuntary discharge and he has no one to advocate for him. We did a new psychological evaluation and the results were (R1) is alert and oriented, decision making skills are there also but (R1) would not be able to live alone. (R1) would not be able to take care of himself, we are asking his brother to help assist us with placement elsewhere. No progress for this goal so far. (R1) is his own person but he can not take care of himself. The Ombudsman organization is helping with the discharge process they are going to file for a hearing due to the involuntary discharge and the facility (R1) was at is the only place (R1) has been in the last 20 some years. V19, Nurse Practitioner for the contracted company who works with the mental health clients for the facility stated in interview on 11/18/25 at 12:02 PM, I agree with the assessment (R1) received at the hospital.		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement care planned interventions for dementia related wandering behavior for one of four residents (R3) reviewed for abuse in the sample list of seven. Findings include: The facility's undated Abuse Prevention Policy documents Resident Assessment: As part of the resident's life history on the admission assessment, comprehensive care plan, and MDS (Minimum Data Set) assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment, history of trauma or misappropriation of resident property, who have needs, triggers and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of abuse, neglect, exploitation, mistreatment or misappropriation of resident property for these residents. Staff will continue to monitor the goals and approaches on a regular basis and update as necessary. The facility's State of Illinois Department of Public Health Long-Term Care Facility & IID -Serious Injury Incident Report dated 10/23/25 at 4:10 PM documents on 10/16/25 at 2:20 PM R2 open handed smacked R3 on R3's right upper arm. R2 stated R2 acted in retaliation claiming that R3 hit R2 first, however witnesses did not support that R3 hit R2. V8 Certified Nursing Assistant (CNA) written Witness Statement dated 10/16/25 documents V8 was coming out of the CNA room and R3 grabbed onto the armrest of R2's wheelchair and R2 started smacking R3's arm. V8 immediately separated R2 and R3. R3's MDS dated [DATE] documents R3 has short and long term memory impairment, is moderately impaired with cognitive skills for daily decision making and wanders. R3's active care plan documents R3's diagnoses include Dementia and Paranoid Schizophrenia, and a problem dated 10/25/23 that R3 wanders the hallways, into other resident rooms and gets into unoccupied beds. Interventions include to provide structured activities such as toileting, walking inside and outside, and reorientation strategies including signs, pictures and memory boxes. On 11/17/25 at 9:36 AM R3 was sitting in the recliner in R3's room. R3 responded to name only but did not respond to any questions. There were no pictures, memory boxes, or signs in R3's room or near the outside of R3's doorway to help R3 identify R3's room. There was only a standard name plate that is used for all residents, with R3's first initial and last name located near R3's doorway. On 11/17/25 at 11:55 AM V14 CNA stated R3 wanders and goes into other resident rooms. V14 stated we try to redirect R3 and R3 is also on 15-minute visual checks. V14 stated R3 relaxes in R3's recliner and enjoys watching television. V14 stated R3's name is outside R3's room door. V14 confirmed this is the same for all residents and lists first initial only. V14 went to R3's room and confirmed there are no pictures, shadow boxes, or signs to identify R3's room. V14 stated signs have been used on room doors to help other residents identify their rooms, but this has not been done for R3. On 11/17/25 at 1:27 PM V8 CNA confirmed V8 witnessed R2's/R3's altercation on 10/16/25. V8 stated the incident happened between 2:00 PM and 2:30 PM. R2 does not like people in R2's personal space and R3 wanders and likes to go into other resident rooms and lay in their beds. R2 may have thought R3 was in R2's room. As R3 wheeled passed on the right side of R2, between the railing and R2, R3 grabbed the arm rest of R2's wheelchair to propel herself. R2 got upset, yelled at R3 and slapped R3 in the right hand three times reprimanding R3 like you would a child. R3 had room changes over the last year and since then R3's wandering has been worse. R3 does recognize things in her room, likes her jewelry and bedding. V8 was asked if any pictures or signs had been used to help R3 identify her room. V8 stated that is a good idea, that might help R3 recognize R3's room. V8 confirmed pictures and signs had not been used.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review the facility failed to document a resident to resident altercation in the electronic medical record for two of four residents (R2, R3) reviewed for abuse in the sample list of seven. Findings include: The facility's State of Illinois Department of Public Health Long-Term Care Facility & IID -Serious Injury Incident Report dated 10/23/25 at 4:10 PM documents on 10/16/25 at 2:20 PM R2 open handed smacked R3 on R3's right upper arm. R2 stated R2 acted in retaliation claiming that R3 hit R2 first, however witnesses did not support that R3 hit R2. R2's and R3's electronic medical records (EMRs) did not include documentation of the 10/16/25 altercation. On 11/17/25 at 1:10 PM R2 stated R3 gets in people's rooms and sleeps in their beds and the facility hasn't done much about it. R2 stated there was one time that R3 got physical with R2 on an unidentified date. R3 tried to go into R2's room, R3 banged on my (R2's) arm, so I (R2) banged her (R3) back in the arm. On 11/17/25 at 1:27 PM V8 CNA confirmed V8 witnessed R2's/R3's altercation on 10/16/25. V8 stated the incident happened between 2:00 PM and 2:30 PM. V8 witnessed R3 wheel past and grab onto R2's wheelchair armrest. R2 got upset with R3, yelled at R3 and slapped R3 in the right hand three times reprimanding R3 like you would a child. R2's hit was intentional. V8 described R2 as being with it, knows staff, and alert/oriented to person, place, time and situation. V8 stated R3 is confused and in her (R3's) own world. On 11/17/25 at 12:05 PM V5 Licensed Practical Nurse was asked where V5 documented R2's/R3's incident in their EMR. V5 stated to ask V2 Director of Nursing (DON) since V2 took over the incident, and all V5 documented was that R2 was on initial constant supervision which changed to 15-minute checks. On 11/17/25 at 2:05 PM V2 DON stated resident to resident altercations are documented in risk management and confirmed this incident was not documented in R2's or R3's EMRs. V2 stated V5 was R2's nurse that day and would have made the notifications to the family and physician, which V5 usually documents in a progress note. V2 stated V15 Registered Nurse may have notified R3's family and physician, and all of this would be documented in risk management. On 11/17/25 at 3:40 PM V1 Administrator stated resident to resident altercations are documented in risk management and V1 thought staff documented the incident in the EMR in a progress note. The facility's undated Abuse Prevention Policy documents all incidents will be documented, whether or not abuse occurred, was alleged or suspected.		