

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 11/08/2024
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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 34058 Based on interview and record review, the facility failed to obtain a new Level 2 PASRR (Preadmission Screening and Resident Review) to evaluate a resident's need for specialized mental health services upon the expiration of the initial Level 2 evaluation. This failure affects one resident (R28) out of 11 reviewed for pre-admission screening on the sample list of 31. Findings include: R28's Level 2 PASRR to evaluate for the need of specialized mental health services dated 8/17/2015 documents R28 had a history of inpatient mental health hospitalization s, experienced delusions, irritability, and difficulty remaining on tasks related to her medical diagnosis of Paranoid Schizophrenia. This Level 2 screening had a determination date of 8/24/2015 and documented R28 required specialized services including mental health rehabilitation services, illness self-management, and community re-integration activities. This Level 2 screening documented this determination was valid for 90 days from the date of determination (11/22/2015), and a new determination should be obtained from the entity treating the individual on 11/22/2015. On 11/7/24 at 10:08 AM, V10, Business Office Manager, and V7, Social Services Director, stated they did not have any documentation more current than the Level 2 PASRR from 8/17/2015. At 10:31 AM, V10 stated, I called the (screening agency) and they did not have any records of a more recent screening. V10 further stated, The Level 1 screening is good for 30 days so the resident would have to be admitted to the facility within that 30 days, but the Level 2 can be limited to 90 days and then they would need another Level 2 in that 90 days.		

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on interview and record review the facility failed to complete a baseline careplan timely for one resident (R270) out of one reviewed for careplans in a sample list of 31 residents. Findings include: The facility policy titled Baseline Care Planning policy revised 3/16/22 documents the following procedure shall be utilized in developing a baseline careplan (BCP). A BCP shall be developed to include instructions needed to provide effective person centered care to each resident, based on his/her initial assessment and the professional standards of quality of care, to serve as a functional guide in delivery of care until such time as a comprehensive careplan is developed. R270's undated Face Sheet documents R270 admitted to facility on 10/31/24 with medical diagnoses of Wedge Compression Fracture of T9-T10 Vertebrae, Dementia, and Hypertension. R270's Admission assessment dated [DATE] documents R270 is alert and oriented to person only. R270's Nurse Progress Note dated 11/4/24 at 5:42 AM documents 4:25 AM (R270) fell . Full physical assessment done. Moves all extremities well ([NAME]). Alert and oriented x 1. (R270) complained of pain to ribs and underarms. This same note documents R270 was sent to the emergency room for evaluation. R270's Care plan does not include a focus area, goal nor interventions prior to R270's fall on 11/4/24. R270's baseline careplan was initiated on 11/6/24. On 11/8/24 at 12:10 PM V4 Care Plan Coordinator (CPC)/Licensed Practical Nurse (LPN) stated each department is responsible for entering their own component of the resident careplan. V4 stated V4 is responsible for the nursing portion of the resident careplan. V4 stated V4 completes the baseline resident careplan within the first week of the resident's admission. V4 stated V4 was not aware that there was any timeframe that baseline careplan had to be completed. On 11/8/24 at 12:30 PM V1 Administrator stated the resident's baseline careplan should be completed within 48 hours. V1 stated there is a baseline assessment that is completed upon admission but that assessment does not include goals or interventions for the staff to use to provide interventions.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 34058 Based on observation, interview, and record review, the facility failed to implement care planned post fall interventions for fall prevention. This failure affects one resident (R59) out of seven reviewed for falls on the sample list of 31. Findings include: On 11/6/24 at 10:43 AM, R59 was seated in her own room in a wheelchair. R59 had a power cord for a personal alarm hanging from the back of her wheelchair but the actual alarming module was not present. R59's Care Plan (undated) documents R59 experienced actual falls on 6/9/24 and 6/10/24. This care plan documents the post fall intervention from the fall on 6/9/24 was to provide an alarm on R59's wheelchair. R59's Nursing Progress Notes dated 6/9/24 documents R59 was seated in her wheelchair just prior to being noted on the floor sitting on her buttocks with her legs outstretched. R59's Nursing Progress Notes dated 6/10/24 documents R59 was sitting on her buttocks on the floor with her wheelchair next to her. On 11/6/24 at 11:00 AM, V4, Licensed Practical Nurse/ Care Plan Coordinator, reviewed R59's care plan and stated, Yes, (R59) is supposed to have an alarm on her bed and wheelchair. V4 accompanied (surveyor) to observe R59's alarms, V4 confirmed there was not an alarm present on R59's wheelchair, simply the power cord, then stated, I will have to fix this.		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 34058 Based on interview and record review, the facility failed to provide the services of a Registered Nurse for eight consecutive hours per day seven days per week. This failure has the potential to affect all 69 residents residing in the facility. Findings include: The facility's Nurses Schedule for October and November 2024 documents on 11/2/24, 11/5/24, and 10/29/24, there was not a registered nurse scheduled to work. The October Nurses Schedule documents on 10/27/24 there was a registered nurse working for four hours. On 11/8/24 at 9:15 AM, V1, Administrator, reviewed the Nurses Schedules and stated, I don't see an RN (Registered Nurse) on 11/3/(24), I don't see an RN on 11/5/(24), I don't see an RN on 10/29/(24). Correct on 10/27/(24) there was an RN for four hours. V1 further stated, We knew we would get this (citation), facilities are struggling with staffing. The facility's Form 802 Resident Matrix dated 11/6/24 documents 69 residents reside in the facility. The Department of Health and Human Services Center for Medicare and Medicaid Services Certification and Transmittal dated 10/4/23 documents all 100 beds in the facility are Certified Skilled Nursing Facility (SNF).		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41970 Based on observation, interview and record review the facility failed to prevent cross contamination during medication administration for four residents (R13, R56, R51, R270) out of six reviewed for medication administration in a sample list of 31 residents. Findings include: The facility policy titled Medication Administration revised 11/18/2017 documents appropriate hand washing is to be completed and/or alcohol based gel rub must be used throughout the medication pass. This should occur before and after medication pass and after touching an inanimate object possibly contaminated with microorganisms. Handwashing is not required per the Centers for Disease control (CDC) guidelines. It is acceptable to use alcohol based gel type solution between residents. The Facility Daily Midnight Census dated 11/6/2024 documents 69 residents reside in facility. On 11/7/24 at 7:22 AM V12 Licensed Practical Nurse (LPN) administered R56's medications. V12 LPN did not wash hands nor use an alcohol based hand rub (ABHR) prior to administering R56's medications. V12 LPN then proceeded to administer R270's medications without using ABHR nor washing her hands. V12 LPN then administered R13's medications without using ABHR nor washing her hands. V12 LPN then administered R51's medications without using ABHR nor washing her hands. A bottle of ABHR was sitting on top of V12 LPN's medication cart while V12 was passing medications to residents. V12 LPN touched dozens of medication cards, the top and front of the medication cart, the computer screen, the plastic medicine cups/water cups and the water pitcher when preparing each residents medications. V12 LPN also touched resident doors, privacy curtains and bedside tables when administering resident medications without washing her hands nor using ABHR when administering medications to the same four residents (R13, R51, R56 R270). On 11/7/24 at 7:30 AM V12 Licensed Practical Nurse (LPN) stated V12 should have used hand hygiene before administering medications and also in between administering medications to multiple residents, V12 LPN stated not using hand hygiene could result in bacteria being spread resident to resident. On 11/7/24 at 2:30 PM V2 Regional Director of Nursing (DON) stated facility nurses should use hand hygiene between every resident when administering medications.		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 35347 Based on observation, interview, and record review, the facility failed to maintain resident bed side rails in a safe condition. This failure affects one resident (R12) of five reviewed for bed side rails in the sample list of 31. Findings include: R12's medical diagnosis list (11/7/2024) documents R12's diagnoses include: Extrapyrarnidal and Movement Disorder, Left Knee Valgus Deformity (abnormal angle to the lower leg), and Dementia. R12's quarterly assessment (9/11/2024) documents R12 has impaired range of motion in both lower extremities. R12's Fall Risk Evaluation (9/11/2024) documents R12 has a recent history of falling in the facility. R12's Bed Rail Evaluation (9/11/2024) documents R12's bed side rail serves as an enabler to promote independence in entering and/or exiting R12's bed. R12's Care Plan (11/7/2024) documents R12 utilizes a bed side rail for mobility and staff should encourage R12 to use the side rail to promote R12's independence. On 11/6/2024 at 10:11AM, R12's half-length right side bed rail was in the upward position. The rail appeared loose and was leaning outwardly towards the center of R12's room. When lightly touched, the rail easily moved back and forth towards R12's mattress as well as left and right towards the floor. A five and one half inch gap was present between the side rail and mattress as measured by Illinois Department of Public Health measuring tape. R12 was present and reported using the rail to get up in bed and reported the side rail had been loose for a long time. On 11/7/2024 at 2:00PM, R12's right side bed rail remained in the upward position. When grasped, the entire bed rail easily moved back and forth towards the mattress a total distance of seven inches as measured by (State Agency) measuring tape. The rail also pivoted left and right about it's central point a distance of six inches towards the floor. R12 was present and stated it (the excessively loose side rail) is just hanging there and I'm worried about it. On 11/7/2024 at 2:03PM, V11 (Licensed Practical Nurse) observed the above rail and V11 reported the side rail needed replaced and was a concern since R12 uses the rail for transfers. The Food and Drug Administration Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment (3/10/2006) documents to reduce the risk of entrapment, injury, and death, the maximum safe spacing in a bed side rail system should not exceed 4 3/4.		