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	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven of Arcola	422 East Fourth Street Arcola, IL 61910

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide the services of a registered nurse for eight consecutive hours seven days a week every twenty-four hours. This failure has the potential to affect all 65 residents who reside in the facility.The Long-Term Care Facility Application for Medicare and Medicaid dated 9/7/25 documents 65 residents reside at the facility.The facility's Staffing Policy that is not dated was provided by V1 Administrator and documents that a Registered Nurse (RN) will be scheduled seven days a week at least one continuous (8) eight-hour shift. The facility's nursing work schedule for the month of August 2025 and September 2025 documents the facility did not have the services of a RN for eight consecutive hours on 8/25/25, 8/30/25, and 9/10/25. The facility's 24-Hour staffing sheet dated Wednesday, September 10, 2025, documents that there were no RN's scheduled during this 24-hour period. The facility assessment dated [DATE] documents that facility accepts residents with a variety of clinically complex conditions. The facility assessment documents that Registered Nurses are provided by the facility.On 9/09/25 at 8:29 AM, V1 Administrator confirmed there were no Registered Nurses on duty for eight consecutive hours on 1/1/25, 3/31/25, 8/25/25, and 8/30/25. On 9/09/25 at 1:15 PM, V1 Administrator confirmed there were no Registered Nurses on duty for eight consecutive hours on 9/10/25.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement interventions and monitoring for hyponatremia (low sodium) with repeated hospitalizations for one of three residents (R40) reviewed for hospitalizations in the sample list of 33.R40's Minimum Data Set (MDS) dated [DATE] documents R40 has moderate cognitive impairment.R40's September 2025 Medication Administration Record (MAR) documents R40 receives the following psychotropic medications: Fluoxetine 60 milligrams (mg) by mouth (PO) daily, Mirtazapine 15 mg PO daily, Olanzapine 22.5 mg PO daily, Divalproex 500 mg PO twice daily, and Clorazepate Dipotassium 7.5 mg PO daily.R40's emergency room Discharge Instructions dated 5/2/25 documents the following: R40 had hyponatremia and urinary tract infection, follow up with V21 Physician within 2-4 days, and R40 will need sodium level rechecked as it was low today, 128 (normal range 135-145). Some seizure medications and antidepressants can affect sodium levels. Treatment for hyponatremia depends on the cause and may include intravenous (IV) fluids, medication to correct the sodium imbalance, adjustments in medications causing the hyponatremia, and limiting water or fluid intake. R40's Hospital History and Physical dated 5/15/25 documents R40 was transferred to the hospital following a fall. R40's Sodium was 124, R40 was admitted with acute on chronic hyponatremia, urinary tract infection, and pneumonia, and R40 was given 1 liter of Normal Saline IV. R40's Hospital Note dated 5/20/25 documents laboratory workup confirmed Syndrome of Inappropriate Antidiuretic Hormone Secretion (a condition that leads to excessive water retention and low sodium levels) improved with fluid restriction which was lifted on 5/19/25 when R40's sodium was 135.R40's physician orders dated 5/21/25 and 5/22/25 document to obtain Comprehensive Metabolic Panel (CMP). R40's Progress Note dated 6/2/25, recorded by V19 Nurse Practitioner, documents to recheck CMP. There is no documentation in R40's electronic medical record that a CMP was completed as ordered on these dates, and there is only one CMP that was completed on 7/14/25.R40's Hospital History and Physical dated 7/2/25 documents R40 was sent to the hospital for altered mental status, R40's sodium level was 120, serum osmolality was 265 (normal range 280-300), and urine sodium was less than 15. It was suspected that R40 was experiencing hypovolemic hyponatremia, but R40 reported having good oral intake and denied vomiting/diarrhea. R40 admitted with hyponatremia, and was given intravenous fluids.R40's Hospital Note dated 8/15/25 documents R40 was transferred to the hospital due to urinary retention, altered mental status, lethargy; and the facility reported R40 was given IV fluids and catheter was changed, but no output. R40's sodium level was 125 and R40's admission diagnoses included acute encephalopathy likely secondary to urinary tract infection and hyponatremia. R40's Hospital Note dated 8/16/25 documents R40's sodium level had increased to 134.R40's active care plan does not address a problem, goals, and interventions to address R40's reoccurring hyponatremia. R40's active physician's orders as of 9/8/25, do not document any routine laboratory orders (labs).On 9/07/2025 at 8:31 AM R40 was unable to provide details regarding his hospitalizations within the last six months.On 9/09/2025 at 10:15 AM V7 Licensed Practical Nurse stated you would have to talk to the DON (V2 Director of Nursing) about that, when V7 was asked what was being done to address R40's hyponatremia. V7 stated labs are done upon readmission and routinely as ordered by the provider.On 9/9/25 at 10:31 V2 DON was asked about interventions regarding R40's hyponatremia. V2 stated R40 receives intravenous vitamin infusions monthly. V2 confirmed R40's care plan should address hyponatremia and interventions. At 12:47 PM V2 confirmed R40's care plan does not address hyponatremia and V23 MDS/Care Plan Coordinator did not care plan for this problem due to thinking it was an acute condition. At 2:35 PM V2 confirmed R40's monthly vitamin infusion was the only intervention for R40's hyponatremia. V2 confirmed R40 does not have any orders for routine monitoring of sodium level. V2 confirmed R40's orders for sodium level after hospital discharge on [DATE] and on 5/21/25, and confirmed there is no documentation these orders were completed. V2 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated the facility uses the laboratory at the local hospital. At this time V2 called the local hospital laboratory and confirmed R40 did not have any labs drawn between 5/2/25 and 7/1/25, other than the labs drawn in the emergency room.On 9/9/25 at 3:22 PM V19 Nurse Practitioner stated the cause of R40's hyponatremia is likely due to his psychotropic medications, R40 takes Zyprexa which affects sodium. V19 stated due to R40's psychiatric diagnoses R40's psychiatric medications shouldn't be adjusted. V19 stated V19 does not feel comfortable ordering a routine dose of sodium bicarbonate due to R40's sodium level fluctuating. V19 stated V2 just spoke with V19 regarding the concerns with monitoring and interventions for R40's hyponatremia, V19 gave orders for monthly Basic Metabolic Panel and adjustments can be made to R40's monthly IV vitamin infusions. V19 confirmed R40's hyponatremia could have been identified prior to R40's hospitalizations if labs were completed as ordered and R40's decline could have been identified sooner. V19 stated hyponatremia was not the primary admitting diagnosis for his hospitalizations. V19 stated if R40's hyponatremia was identified sooner and reported to V19, V19 would have ordered a short-term sodium supplement and to recheck R40's labs. V19 stated if hyponatremia is undetected/untreated it can lead to neurological side effects such as dizziness, lethargy, confusion, and altered mental status; and if severe it can cause seizures. The facility's undated Physician Order Guideline documents nurses are responsible for executing the physician's orders, place orders into the resident's electronic medical record, and contact laboratory services as required to execute the order.

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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. Based on observation, interview, and record review the facility failed to implement Enhanced Barrier Precautions (EBP), perform hand hygiene, properly disinfect equipment and maintain a urinary catheter bag off the floor for three of 17 residents (R12, R40, R43) reviewed for infection control in the sample list of 33. 1.) On 9/07/2025 at 8:31 AM R40's door contained a sign indicating R40 was on EBP and to wear gown and gloves for high contact care, including assistance with dressing, transfers, and care of indwelling devices. PPE (Personal Protective Equipment) was present in a container on R40's door. R40 was lying in bed and R40's urinary catheter drainage bag was on the side of the bed. R40 stated R40 has had the catheter for a few months and has had urinary tract infections (UTIs). R40 stated the staff do not wear gown and gloves when providing R40's cares. On 9/07/2025 at 9:03 AM V18 Certified Nursing Assistant (CNA) entered R40's room, transferred R40 out of bed and into the wheelchair, and changed R40's bed linens. V18 was not wearing gloves or a gown for this care. On 9/08/2025 at 11:34 AM V14 CNA entered R40's room, transferred R40 out of bed, and assisted R40 to walk down the hallway using a wheeled walker and gait belt. V14 was not wearing any PPE for R40's cares. At 11:45 AM V14 stated R40 is on EBP for his urinary catheter and staff wear gown only when doing catheter related care. V14 confirmed V14 does not wear a gown and gloves when assisting R40 with dressing and transfers. On 9/08/2025 at 1:35 PM V11 CNA entered R40's room, emptied R40's catheter, and V11 was not wearing a gown. On 9/8/25 at 1:39 PM V18 CNA assisted R40 to standing position and back into bed and placed the catheter drainage bag on the bottom of the bed frame causing the bottom half of the bag to be on the floor. V18 provided R40's urinary catheter care/cleansing. V18 wore gloves but did not wear a gown during R40's care and did not perform hand hygiene prior to or after R40's catheter care. V7 Licensed Practical Nurse applied a catheter securement device to R40's left thigh and attached the urinary catheter. V7 did not wear a gown for R40's catheter care. On 9/08/2025 at 2:02 PM V18 was asked about EBP. V18 stated V18 thought it had to do with using a towel as a barrier on the overbed table during catheter care or applying barrier cream. V18 confirmed he does not wear a gown for any of the cares listed on the EBP sign on R40's door. V18 stated he was not aware of EBP. V18 confirmed V18 did not perform hand hygiene prior to or after providing R40's catheter care. On 9/9/25 at 11:40 AM V18 confirmed R40's catheter drainage bag was touching the floor during R40's observed catheter care and confirmed catheter bags are supposed to be kept off of the floor. On 9/08/2025 at 2:09 PM V7 stated EBP is followed when dealing with R40's urine and catheter. V7 was not aware that a gown should be worn for any other cares, only if it deals with the catheter. R40's May-September 2025 Nursing Notes document R40 received antibiotic treatment for UTIs on at least four different occasions. R40's Nursing Note dated 8/19/2025 documents R40 admitted to the hospital for UTI with methicillin resistant staphylococcus aureus, an MDRO. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 09/08/2025 4:33 PM a sign was present on R43's door indicating R43 is on Enhanced Barrier Precautions. At this time V27 Registered Nurse accessed R43's feeding tube and V27 did not wear a gown. 3. On 09/09/2025 at 10:45AM V13 Licensed Practical Nurse completed wound care for R12. V13 donned a gown and gloves after completing hand hygiene with alcohol-based hand cleanser. V13 removed the old dressing from R12's wound which was dated 9/8/25 and removed iodoform gauze. V13 cleaned the wound with wound cleanser, cotton tipped applicators, and gauze pads. V13 discarded V13's gloves and cleansed hands then donned clean gloves. V13 inserted clean iodoform gauze strips into R12's tunneling stage IV Pressure Ulcer. The wound was draining large amounts of gray, brown liquid and was odorous. V13 cut the Iodoform packing with the scissors she had in the room. V13 then covered the wound with a super absorbent gauze pad and bordered foam dressing. V13 took the scissors to the utility room and cleaned the scissors with soap and water after using them to cut gauze strips in R12's draining wound. No bleach solution was used. V13 stated I guess I should have used a bleach wipe to clean the scissors. The facility's EBP policy dated 3/21/25 documents EBP is implemented to prevent the transmission of multidrug-resistant organisms (MDRO), gown and gloves are worn during high-contact resident care activities for residents colonized or infected with MDRO and for those at increased risk of acquiring MDRO through wounds or indwelling medical devices. This policy documents staff should be trained on EBP upon hire and annually, signage will be posted outside of the resident's room to identify precautions, Personal Protective Equipment (PPE), and high contact care activities that requires the use of gown and gloves. This policy documents high-contact resident care activities includes assistance with dressing, bathing, transferring, hygiene, changing linens, toileting/incontinence, device care, and wound care. The facility's Urinary Catheter Care policy dated September 2005 documents to be sure the catheter tubing and drainage bag are kept off the floor and to perform hand hygiene prior to and after performing urinary catheter care. The facility's Handwashing/Hand Hygiene Policy dated March 2020 documents staff should practice hand hygiene/handwashing as primary means in preventing the spread of infection and alcohol-based hand rubs can be used as hand hygiene when hands are not visibly soiled or contaminated. This policy documents hand hygiene should be performed after handling potentially contaminated equipment or medical devices.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to honor a female resident's request to have her shower done by female staff for one (R14) of one resident reviewed for choices on a sample list of 33.Findings include:The facility's Resident Rights Guideline dated 10/2023 documents that it is the practice of the facility to provide for an environment in which residents may exercise their rights, each day. Residents have certain rights and protections under Federal law. This policy documents that the facility will meet and provide these rights through care and related services at all times. R14's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of fifteen indicating that R14 has normal cognitive function.On 9/07/25 at 9:12 AM, R14 stated that she doesn't want V16 male Certified Nursing Assistant (CNA) helping R14 with shower because V16 doesn't get R14 clean. R14 stated she told V11 CNA and R14 was told that R14 would have to take her shower in the evening if R14 didn't want V16 helping. R14 stated R14 was agreeable to that but that nothing has changed.R14's MDS Section GG0130 (Self-Care Shower/bathe self) dated 12/13/24 documents that R14 requires supervision or touching assistance with bathing including washing, rinsing, and drying self.R14's Care Plan dated 11/18/24 documents that R14 requires supervision assistance with Activities of Daily Living (ADL's) and partial assistance with showering. This Care Plan lists an intervention for staff to provide supportive care, and assistance with mobility as needed. A 30-day lookback at R14's electronic medical record and shower sheets documents that R14 received showers with help from V16 male CNA on 8/13/25, 8/18/25, 8/20/25 8/25/25, 9/01/25, and 9/03/25.On 9/08/25 at 9:44 AM, V6 CNA stated R14 asked V6 that morning if V6 could be the one to help R14 with her shower. On 9/09/25 at 10:04 AM, V11 CNA stated V16 CNA does help R14 with showers sometimes.On 9/08/25 at 1:53 PM, V2 Director of Nursing stated that it is R14's right to choose who helps R14 with showers. V2 stated that she was not aware R14 wanted only females helping with R14's showers and that V2 would look into it.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide quarterly statements of personal funds accounts for two of two residents (R4, R8) reviewed for personal funds in the sample list of 33The facility's undated Quarterly Trust Statements Policy documents quarterly statements are sent out by the last day of the following month by the business office. This policy documents to make two copies of the statements, one to keep for records and one to give to the resident/responsible party. This policy documents to keep a spreadsheet and indicate next to the resident's name when a copy was mailed to the resident's representative, and attach a copy of the statement. This policy documents to have the resident sign his/her name on the spread sheet to indicate they received their quarterly statement and upload a copy of the statement into the resident's electronic medical record. 1.) On 9/7/25 at 8:59 AM R8 stated R8 has money in a personal funds account, but R8 does not know how much money is in the account and doesn't receive quarterly statements. On 9/9/25 at 12:04 PM V20 (R8's Guardian) confirmed R8 has a personal funds account at the facility. V20 stated V20 receives billing statements from the facility, but was unsure if the facility sends quarterly statements of R8's personal funds account. R8's Statement dated 9/9/25 documents accounting of deposits, withdrawals, and interest 11/21/24-9/9/25. There is no documentation when R8's quarterly statements were sent to V20. 2.) On 9/7/25 at 9:48 AM R4 stated R4 has money in a personal funds account, but R4 does not know how much money is in the account and doesn't receive quarterly statements from the facility. R4's Minimum Data Set, dated [DATE] documents R4 as cognitively intact. R4's active profile documents R4 as responsible party/guarantor (handles her own finances.) R4's Statement dated 9/9/25 documents accounting of deposits, withdrawals, and interest 6/2/24-9/3/25. There is no documentation when R4's quarterly statements were provided. On 9/09/2025 at 11:48 AM V24 Business Office Manager stated personal funds account statements are provided to the residents quarterly and upon request. V24 stated R8's statements are sent to V20 and R4's statements are given to R4. V24 stated V24 does not have documentation when the statements are provided and doesn't have the residents sign when their statements are provided. V24 stated V24 used to document when statements were provided, but has no longer been doing that since the facility changed ownership.

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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 written notice of transfer and bed hold for hospitalizations for one of three residents (R13) reviewed for hospitalizations in the sample list of 33. The facility's Bed Hold and readmission Policy dated November 2016 documents it is the facility's policy to readmit residents after hospitalization and the facility will hold a specific bed or make available the next semi-private accommodation if the resident chooses not to hold the specific bed. This policy documents the resident/representative shall be informed of this policy on admission and at the time of transfer to a hospital, and provided written notification at the time of transfer. This policy documents in the event of an emergency hospitalization the resident/representative can be notified by telephone and may verbally give the bed hold determination, which should be documented in the progress notes and follow up written confirmation may be required. On 9/07/2025 at 10:47 AM R13 stated R13 goes to the hospital 3-4 times per year. R13 could not elaborate further on what R13 was hospitalized for. R13's ongoing census documents R13 was hospitalized [DATE]-[DATE], 6/6/26, 7/18/25-7/19/25, and 7/31/25-8/5/25. R13's electronic medical record does not contain documentation that a written notice of transfer and bed hold was provided for R13's 4/15/25 and 7/18/25 hospitalizations. On 9/08/2025 at 11:49 AM V7 Licensed Practical Nurse stated bed hold/transfer notices are documented under the assessments tab of the resident's electronic medical record (EMR) and are printed and given to the resident upon discharge to the hospital. On 9/8/25 at 12:00 PM V2 Director of Nursing stated bed hold/transfer notices are provided upon discharge to the hospital and have been faxed to the hospital in the event of an emergent transfer. V2 stated bed hold/transfer notices are documented under the assessments or uploaded as a paper form into the miscellaneous section of the resident's EMR. At 1:05 PM V2 provided R13's written notice of bed hold/transfers dated 4/13/24, 6/6/25 and 7/31/25. V2 confirmed there was no documentation of written bed hold/transfer notice for R13's 4/15/25 and 7/18/25 hospitalizations.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to assess/measure a pressure sore, administer a wound treatment according to physician's orders and accurately document the location of a pressure sore for one resident (R12) of two residents reviewed for pressure sores in a sample list of 33. Findings Include: R12's Care Plan updated 6/16/25 lists the following diagnoses: Hypomagnesemia, Chronic Pulmonary Edema, Quadriplegia, C5-C7 Complete, Neuromuscular Dysfunction of Bladder, Seizures, Cauda Equina Syndrome, Zoster Encephalitis, and Primary insomnia. R12's MDS Minimum Data Set, dated [DATE] documents R12 is cognitively intact. R12's admission Skin assessment dated [DATE] documents a Superficial wound (to the) Right Gluteal Fold measuring 0.2cm (centimeters) in Length by 0.2cm in width by 0cm in depth. R12's Physician's Order sheet documents a physician's order started on 4/24/25 and discontinued on 5/15/25 R (right) upper thigh. Cleanse with normal saline. Apply Mepilex every day shift every 3 day (s) for wound. R12's 4/28/25 Skin assessment tool is completely blank. R12's 5/7/25 Skin assessment tool does not contain measurements but documents Continue Mepilex treatment to Right Gluteal fold. Wound prevention had superficial wound. R12's 5/12/25 Skin assessment tool is completely blank.On 6/10/25 at 11:30AM V1 administrator and V26, Corporate Registered Nurse verified no wound assessments were completed on 4/28/25,or 5/12/25 and no wound measurements were completed 5/7/25. V26 stated I see the wound assessments were left blank on 4/28/25 or 5/12/25 and no measurements were documented 5/7/25. If the wound assessments were done they would have been documented on the blank wound assessments.R12's Physician's Order sheet documents a physician's order started on 5/17/25 and discontinued on 5/22/25 Right gluteal fold Cleanse with wound cleanser. Apply collagen to wound bed then cover with hydrocolloid dressing 3x (times) a week et PRN (and as needed) every day shift every Tue, Thu, Sat (Tuesday, Thursday, Saturday) for wound. On 9/10/25 at 1045AM V22, Licensed Practical Nurse (LPN) stated (R12) had just one wound. Some people charted it as the right upper thigh and others charted it as the right gluteal fold. It was the same wound. V22 verified that she has been with the facility several years and regularly cares for R12 and does his treatment. R12's Wound Assessment and Plan by V25, Wound Care Nurse Practitioner dated 5/15/25 documents R12 had a Stage III Pressure Ulcer 0.5cm long by 1.5cm in width by 0.5cm in depth. Wound onset date 4/21/25, Site: Right Gluteal Fold. R12's Wound Assessment and Plan by V25, Wound Care Nurse Practitioner dated 5/22/25 documents the wound had increased in size to 1.0cm long by 1.9cm in width by 0.5cm in depth. There is no documented assessment 5/29/25. R12's Wound Assessment and Plan by V25, Wound Care Nurse Practitioner dated 6/5/25 documents the wound had increased in size to 1.5cm long by 1.0cm in width by 1.6cm in depth and now has a moderate amount of exudate. R12's Wound Assessment and Plan by V25, Wound Care Nurse Practitioner dated 6/12/25 documents the wound had increased in size to 1.5cm long by 1.5cm in width by 2.6cm in depth. R12's Wound assessment and Plan by V25, Wound Care Nurse Practitioner dated 6/20/25 documents the wound had increased in size to 1.0cm long by 1.7cm in width by 2.1cm in depth. The wound is now documented to be a stage 4 pressure sore and there is 0.6cm of tunneling at 12:00 o'clock.On 9/9/25 at 4:29PM V25 stated There was only one wound which was present on admission. My expectation would be that as soon as any wound even a superficial wound is identified a treatment even if it is just barrier cream and regular accurate assessment of the wound should be put in place. I would like to be notified by the facility of any wound as soon as possible.The facility's Quality Assurance Meeting notes dated 6/19/25 document (V25) Wound NP (Nurse Practitioner) and (V4, Licensed Practical Nurse) RCC (Resident Care Coordinator) were doing wound rounds and noted (R12) treatment in place was not the correct treatment per order. On 6/10/25 at 11:30AM V1 administrator and V26, Corporate Registered Nurse verified they were aware of the wrong treatment being in place to R12 on 6/19/25. On 09/09/2025 at 10:45AM V13 Licensed Practical (continued on next page)

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	146050	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven of Arcola	422 East Fourth Street Arcola, IL 61910

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse completed R12's wound care. At that time R12's wound was draining large amounts of gray brown liquid and the wound was odorous.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to have physician's orders for the use and care of Continuous Positive Airway Pressure (CPAP) for one of one resident (R25) reviewed for CPAP use in the sample list of 33. The facility's CPAP/BiPAP (Bilevel Positive Airway Pressure) Support policy dated April 2007 documents to review the physician's order to determine the oxygen flow rate and positive end-expiratory pressure settings. This policy includes to document a general assessment prior to the procedure, time/duration of therapy, CPAP settings, oxygen flow rate, oxygen saturation, and how the resident tolerated the procedure. On 9/07/2025 at 9:27 AM There was a CPAP machine on the overbed table next to R25's bed. The CPAP mask and tubing was in a plastic bag attached to the machine. R25 stated R25 has been in the facility for a few weeks and uses the CPAP at night. R25 stated the staff do not do any care for the CPAP. R25's active census documents R25 admitted to the facility on [DATE]. As of 9/7/25 R25's active physician's orders do no document any orders for the CPAP. There is no documentation in R25's medical record of CPAP use and care/cleaning. On 9/7/25 at 2:15 PM V7 Licensed Practical Nurse (LPN) stated V7 wasn't aware that R25 was using a CPAP. V7 stated there should be a physician's order for settings and night shift provides CPAP care for the tubing and mask cleaning/changes. On 9/07/2025 at 2:20 PM V22 LPN stated R25 was on V22's hall when R25 first admitted and R25 was not using a CPAP at that time. V22 was unsure when R25 started using the CPAP. V22 stated night shift documents CPAP care on the Treatment Administration Record. On 9/07/2025 at 2:24 PM V7 Certified Nursing Assistant stated R25 has been using the CPAP for a few nights. On 9/07/2025 at 2:33 PM V2 Director of Nursing stated CPAP masks should be cleaned weekly with soap and water and there should be a physician order for the CPAP settings. V2 stated V2 was not aware that R25 had a CPAP, and V2 will follow up and obtain orders.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on interview and record review the facility failed to ensure physician visits are documented for one of three (R40) residents reviewed for hospitalization in the sample list of 33. The facility's undated Physician Services Policy documents It is the policy of this facility that each resident admitted to this facility is under the care of a physician licensed in the State and that all physician services will comply with State and Federal regulations for resident care in a licensed facility. The attending physician shall write a progress note at the time of each resident visit and review the resident's total program of care; i.e. (in other words) comprehensive assessments, care plans, medication and treatments, and approving such by signing and dating the current order recap.R40's active census documents R40 has resided in the facility since 2004 and V21 Physician/Medical Director is R40's primary physician. This census documents R40 was hospitalized six times within the last year. R40's electronic medical record does not contain any physician visit notes by V21 within the last year, only specialists and nurse practitioner notes. On 9/10/2025 at 9:28 AM V1 Administrator stated V1 was unable to locate R40's physician progress notes by V21. V1 stated V1 was unsure when R40 was last seen by V21.On 9/10/2025 at 11:20 AM V21 stated V21 keeps his progress notes and does not document his visit notes in the residents' electronic medical record. V21 stated the facility would have to request his notes. V21 stated yesterday the facility requested R40's physician visit notes, but V21 was unable to locate any. V21 stated V21 has evaluated R40, but was unable to give a specific date or provide the last physician progress note. V21 stated V21 searched R40's name and did not find any notes in the database.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. Based on interview and record review the facility failed to ensure timely physician visits for one of three residents (R40) reviewed for hospitalizations in the sample list of 33. The facility's undated Physician Services Policy documents It is the policy of this facility that each resident admitted to this facility is under the care of a physician licensed in the State and that all physician services will comply with State and Federal regulations for resident care in a licensed facility. The attending physician shall write a progress note at the time of each resident visit and review the resident's total program of care; i.e. (in other words) comprehensive assessments, care plans, medication and treatments, and approving such by signing and dating the current order recap. The attending physician shall certify upon admission and at each visit every 30/60 days thereafter what level of care the resident requires, and document the (reason) for a change in the progress notes.R40's active census documents R40 has resided in the facility since 2004 and V21 Physician/Medical Director is R40's primary physician. This census documents R40 was hospitalized six times within the last year. R40's electronic medical record does not contain any physician visit notes by V21 within the last year, only specialists and nurse practitioner notes. On 9/10/2025 at 9:28 AM V1 Administrator stated V1 was unable to locate any of R40's physician progress notes by V21. V1 stated V1 was unsure when R40 was last seen by V21.On 9/10/2025 at 11:20 AM V21 stated V21 rounds at the facility monthly, but does not see each resident every month. V21 was asked how often V21 evaluates each resident. V21 stated the facility has a fully licensed Nurse Practitioner (V19) that is in the facility frequently to see residents. V21 stated yesterday the facility requested R40's physician visit notes, but V21 was unable to locate any. V21 stated V21 believes he evaluated R40, but was unable to give a specific date or provide R40's last physician progress note.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed log infections, organisms, and antibiotics and ensure the appropriate antibiotics were administered for one (R40) of five residents reviewed for infection control on a sample list of 33. Findings include:The facility's Antibiotic Stewardship Program Guidelines dated 4/29/2024 document that the purpose of the antimicrobial stewardship program is to improve antimicrobial stewardship practices and to monitor outcomes and antimicrobial use. This policy documents that the objective is that the Antimicrobial Stewardship Program will be to improve patient outcomes through optimization of antimicrobial therapy by selection of appropriate antibiotic dose, route, and duration of treatment, minimize the development of antimicrobial resistance by appropriately selecting antibiotics, and reduce the rates of facility-acquired infection. Guidelines document that the facility will monitor antibiotic use and outcomes from antibiotic use. The facility's Infection and Prevention and Control Program dated 1/24/24 documents that the facility's Infection Prevention and Control Program (IPCP), is based upon information from the Facility Assessment including the Infection Control Risk Assessment and follows national standards and guidelines to prevent, recognize and control the onset and spread of infection whenever possible. R40's urine culture results dated 5/2/25 document that there was mixed flora (multiple species present) in R40's urine and no sensitivity was performed. On 9/10/25 at 8:56 AM, V4 Infection Preventionist (IP) stated that on May 2, 2025, R40 did have his urine checked for infection and it was a contaminated. V4 stated R40 was put on an antibiotic (Cephalexin 500 milligrams) and that there was no need to repeat the urine test. emergency room (ER) records for R40 document that R40 was seen in the ER on [DATE] and a Computed Tomography scan determined that R40 had inflammation of R40's urinary bladder and pneumonia. These ER notes document that R40 initially received antibiotics Vancomycin and Zosyn and then Ceftriaxone was added based on urine culture results that determined R40 had a urinary tract infection (UTI). The facility's Infection Surveillance Monthly Report dated May 2025 does not document any UTI's or antibiotic usage for R40. 9/9/25 at 3:22 PM, V19 Nurse Practitioner stated she did not see another urine culture following R40's 5/2/25 result that indicated mixed flora. V19 stated mixed flora would be considered as contaminated and therefor it is unknown if he had a true infection. V19 stated you don't know if the antibiotic was the appropriate drug of choice without culture and sensitivity results. V19 confirmed that part of antibiotic stewardship is ensuring the bacteria are susceptible to the antibiotics ordered. V19 confirmed the hospital discharged R40 on Keflex for UTI and this culture was completed at the hospital. V19 stated the hospital is not very good about following up on culture results after a resident discharges from the hospital. V19 stated she wouldn't have ordered a re-culture unless he was symptomatic. V19 reviewed R40's progress notes and stated the staff were documenting that R40 was asymptomatic after returning from the hospital.The facility's Infection Surveillance Monthly Report dated July 2025 documents that R40 began receiving an antibiotic (Ertapenem Sodium) on 7/7/25 for an unknown infection. On 9/10/25 at 8:56 AM, V4 IP could not confirm what organism R40 was being treated for on 7/7/25 and that it should have been documented on the Infection Surveillance log.Progress notes from R40's electronic medical record dated 8/19/25 document that a nurse from the hospital called the facility to report that R40 was returning to the facility with a diagnosis of UTI with staph/MRSA.The facility's Infection Surveillance Monthly Report dated 8/19/25 documents that R40 was receiving an antibiotic (Bactrim) for a UTI but does not include that R40 was being treated for Methicillin-Resistant Staphylococcus Aureus (MRSA).On 9/10/25 at 8:56 AM, V4 IP stated that R40 did have a diagnosis of UTI with MRSA and that it should have been listed on the Infection Surveillance log. V4 provided R40's Case Detail dated 8/19/25 documenting R40's MRSA of R40's urinary tract.