STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000301	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HAVEN OF ARCOLA	422 EAST FOURTH STREET , ARCOLA, Illinois, 61910

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S0000	Initial Comments FRI of 7/18/25/2573947	S0000		08/22/2025
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidence by: 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	S9999		08/22/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 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. The findings include: 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 6/19/25 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 5/22/25 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	S9999		

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S9999	Continued from page 2 happened (R1) stated (R2) was laughing and (R1) believed that (R2) was laughing at him." R6's Minimum Data Set (MDS) dated 7/8/25 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.	S9999		

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S9999	Continued from page 3 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 towels and sheets he had gotten from the linen bin. V4 LPN stated R1 was talking loudly to himself and talking to the voices he hears in his head. V4 LPN stated R1 walked by R2's room. V4 LPN stated R2 has a medical disorder where he laughs uncontrollably. V4 LPN stated V4 had just been in R2's room administering medications to R2's roommate. V4 LPN stated R2 was laying in his bed with the blankets pulled up to his chest just prior to R1 entering R2's room. V4 LPN stated R1 walked by R2's room and then turned around, threw all of the linens in the hallway and walked into R2's room. V4 LPN stated at the same time as V4 was walking down the hall, V5 Activity Assistant was entering the hallway to see what all the yelling was about. V4 LPN stated V5 Activity Assistant was the first to arrive to R2's room. V4 LPN stated V5 had to pull R1 off of R2. V4 LPN stated she saw that R2 had a cut over his Right Upper Lip and R1 had blood coming out of the Left side of his nose. V4 LPN stated R1 stated R2 was laughing at him and it made him mad. V4 LPN stated R2 was visibly shaken up, had a shaky voice and stated to V4 'I don't want to leave my room.' V4 LPN stated R1 and R2 have had a previous altercation 'a few years ago' where R1 hit R2 on the smoking patio. On 8/9/25 at 1:40 PM V5 Activity Assistant (AA) stated he was working the evening of 7/18/25. V5 AA stated R1 had been yelling and talking loudly to himself and pacing up and down the hallway that evening. V5 stated R1 thinks he is the president of the United States and hears voices in his head that tell him to do bad things sometimes. V5 AA stated R1 and R2 have had prior history of R1 hitting R2. V5 AA stated R1 and R2 used to be roommates and had to be separated due to R1 hitting R2. V5 AA stated R2 was laying in his bed when R1 'stormed' into R2's room and began hitting R2. V5 AA stated V5 was the first staff member to get to R2's room. V5 AA stated he saw R1 hitting R2, saw R2 had scratches on both of his arms, a cup upper lip, swollen eye and R1 had a bloody nose. V5 AA stated R1 and R2 were separated. V5 AA stated R1 told V5 that R2 was laughing at R1 and it made him mad. V5 AA stated R2 was very visibly shaken up. The undated facility policy titled Abuse Prevention Policy documents the residents have the right to be free from abuse, neglect, exploitation, misappropriate of property, deprivation of goods and services by staff or mistreatment. This facility prohibits abuse, neglect, exploitation, misappropriate of property and mistreatment of residents. Abuse means any physical or	S9999		

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S9999	Continued from page 4 mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish to a resident. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment. Prior to the survey date of 8/10/25, the facility had taken the following actions to correct the noncompliance: 1. The Quality Assurance Performance Improvement (QAPI) team including V1 Administrator, V15 Vice President of Operations (VPO) and V16 Regional Clinical Nurse (RCN) met on 7/22/25 to identify opportunities for improvement/deficient practice. 2. Immediate action consisted of: R1 and R2 were immediately separated. R1 was sent to the emergency room for evaluation and returned on continual monitoring (1:1) supervision. This continual monitoring was in place until R1 could be seen by psychiatry at which time, R1 was placed on 15 minute visual checks which have remained in place. 3. Actions completed and/or ongoing by 7/25/25: All staff were in serviced on behavioral intervention resources prior to the next shift; All behavioral care plans were reviewed to ensure interventions were in place; All Gradual Dose Reduction (GDR) requests and increases in behaviors within the last three months were reviewed; Behavioral Tracking and GDR audits were scheduled for three times the first week, twice the second week and then weekly for four weeks and were initiated and ongoing and; Resident care plans will be audited weekly for four weeks to ensure timely behavioral interventions are appropriate and effective with behavior tracking in place. Staff in-service on 'Different ways to deescalate behaviors and put interventions in place' was completed on 7/25/25. Care plans and GDRs were reviewed by V1 Administrator, V2 DON and V16 Regional Clinical Nurse. Behavioral care plans and GDR audits were initiated on 7/22/25 and completed on 7/25/25. 4. V1 Administrator will report the findings to the QAPI meeting quarterly. V1 Administrator stated the facility has not had the next QAPI meeting but thus far there have been no new substantiated instances of abuse since 7/18/25.	S9999		

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