STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000376	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA CARE HAVANA	609 NORTH HARPHAM STREET , HAVANA, Illinois, 62644

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Annual Licensure Survey.	S0000		
S9999	Final Observations Statement of Licensure Violations 1 of 3: 300.690a) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. This requirement is not met as evidenced by: Based on interview, observation and record review, the facility failed to identify and thoroughly investigate a resident's injury for one of two residents (R5) reviewed for falls, in a sample of 14. Findings include: The policy Incident and Accident dated 4/2019 documents an Incident/Accident report is completed for all unexplained bruises or abrasions, all accidents or incidents where there is injury. An accident is defined as any happening that result in bodily injury. On 9/2/25 at 9:20 AM, R5 was sitting in her wheelchair next to her bed demonstrating facial grimacing and verbalizing "ouch, oh it hurts" while reaching for her left foot. R5 stated the "other night" (8/31/25), R5 was in her wheelchair waiting to be put to bed for the night, when her roommate (R14) got up and started to fall. R5 reached for R14's hand but R14 fell, pushing R5's wheelchair sideways and R5's foot got stuck under the wheel of the bed. "My foot was stuck under the bed and I was yelling because it (pain) was excruciating. They had to move the bed to get my foot out. I have told everyone how much it hurts and what happened, but	S9999		

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

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S9999	Continued from page 1 they didn't pay any attention to me. I mean "It HURT." R5 stated since then, she has had pain in the left foot and toes which has been "severe". On 9/2/25 at 10:05 AM, V16 (Licensed Practical Nurse/LPN) stated she changed R5's right foot dressing this morning although did not assess R5's left foot, was unaware that R5 had injured her left foot and had increased pain. V16 conducted an assessment of R5's left foot at 10:30 AM. On 9/2/25 at 11:30 AM, V1 (Administrator) provided R14's Comprehensive Fall Assessment (Investigation) dated 9/1/25 at 1:20 AM and did not have an Incident Report for R5 dated 9/1/25. R5's Progress Notes, dated 9/2/25 at 12:05 PM, documents R5's left 2nd and 3rd toe has new skin tears and slight swelling, R5 reported pain as an eight (0-no pain, 10- worst pain), received pain medication, physician and family were notified. On 9/3/25 at 2:00 PM, V2 (Director of Nursing/Wound Nurse) stated she was unaware that R5 had been injured. V2 notified the Physician, pain medication and dressing changes were ordered for R5's left foot toes. V2 stated an incident report should have been completed for R5's left foot injury, reported to and assessed by staff. (No Violation) 1 of 3 300.1630b) Section 300.1630 Administration of Medication b) The facility shall have medication records that shall be used and checked against the licensed prescriber's orders to assure proper administration of medicine to each resident. Medication records shall include or be accompanied by recent photographs or other means of easy, accurate resident identification. Medication records shall contain the resident's name, diagnoses, known allergies, current medications, dosages, directions for use, and, if available, a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility. This requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medication was administered	S9999		

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S9999	Continued from page 2 as ordered for two of twelve residents (R12, R13) reviewed for medication administration, in a sample of 14. Findings include: The Medication Administration policy, dated 1/2015, documents medications must be administered in accordance with a physician's order (right resident, right medication, right dosage, right route and right time). 1. R12 was admitted on 8/18/23 with diagnoses of Generalized Anxiety Disorder, Major Depressive Disorder and Substance Induced Psychoactive Disorder with Hallucinations. R12's Physician's Order, dated 3/22/25, documents Chlorhexidine Gluconate Mouth/Throat Solution 0.12 % give 15 ml (Milliliter) by mouth/swish for 30 seconds and spit it out one time a day. On 9/3/25 at 11:40 AM, V9 (Licensed Practical Nurse/LPN) was observed to hand R12 a medicine cup with the Chlorhexidine solution in it and walk out of the room without ensuring the medications was used for 30 seconds and spit out. 2. R13 was admitted on 12/9/24 with diagnoses of Major Depressive Disorder, Mild Cognitive Impairment and Parkinson's Disease. R13's Physician's Order, dated 12/9/24, documents Carbidopa-Levodopa Oral Tablet 25-100 mg (milligram) give one tablet by mouth three times a day. On 9/3/25 at 11:32 AM, V9 (Licensed Practical Nurse/LPN) was observed to put two tablets of Carbidopa-Levodopa into the medication cup and return the medication card to the medication cart and close the door. V9 left the medication cart and went to administer the two tablets to R13. On 9/3/25 at 11:34 AM, V9 was asked to clarify R13's Carbidopa-Levodopa medication order. V9 stated R13's physician's order was for one tablet (of Carbidopa-Levodopa) and should only get one tablet (of Carbidopa-Levodopa) and she was thinking of another resident that gets two tablets (of Carbidopa/Levodopa). On 9/5/25 at 9:40 AM, V2 (Director of Nursing) stated the nurse should always stay with a resident until the medication is correctly taken. V2 stated Chlorhexidine should not be swallowed and is a "swish and spit" oral	S9999		

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S9999	Continued from page 3 rinse. V2 stated medication name, dose, route and resident should be confirmed prior to administration to ensure the proper medication and dose is given to the right resident. (B) 2 of 3 300.2100 Section 300.2100 Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Code." These REQUIREMENTS are not met as evidenced by: Based on observation, record review, and interview, the facility failed to follow its policy to ensure its kitchen freezer maintained daily temperatures of 0 degrees or less for frozen food items; and failed to ensure food item supplies were not stored on the Food Storage Supply Room floor. These failures have the potential to affect all 44 residents residing at the facility. Findings include: The facility's Food and Supplies Storage Policy, Dated 1/2024, documents: "Policy: Food and supply storage areas shall be maintained in a clean, safe and sanitary manner. 2. Food and supplies will be stored six(6) inches above the floor on clean racks or shelves and at least eighteen (18) inches from sprinkler heads. Acceptable storage area temperatures: Freezer 0 degrees or below. 7. Refrigerators and freezer will be equipped with an internal thermometer and monitored. Temperature will be documented." The facility's Fridge/Freezer Logs, Dated August – September 2025, documents: "Fridges must be kept at 41 degrees F/Fahrenheit – 33 degrees F and freezers must be kept at 0 degrees F or below. The facility's daily temperatures for the facility's Freezer indicated temperatures ranging from 6.3 degrees up to 12.6 degrees." The facility's Resident Roster List, Dated 9/2/25, documents 44 residents reside in the facility. On 9/2/25 at 11:25am, three medium sized unopened boxes	S9999		

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S9999	Continued from page 4 of food supplies sat on the floor of the Food Storage Supply Room. V11 Dietary Manager stated that these arrived on the supply truck yesterday; stated that she was off on that day and that is why the boxes were on the floor. V11 stated that these should not be on the floor. V11 stated, “They (kitchen staff) wait on me to take care of this and get boxes off the floor.” On 9/2/25 at 11:25am, the facility’s freezer, located outside near the back door of the kitchen, showed a temperature of 7 degrees. V11 Dietary confirmed that the freezer temperatures had not been maintained at 0 degrees or less per facility policy and as stated on the facility’s Freezer Logs. (C) 3 of 3 300.2210a) 300.2210b)1)10) Section 300.2210 (a)(b)(1)(2)(10) Maintenance a) Every facility shall have an effective written plan for maintenance, including sufficient staff, appropriate equipment, and adequate supplies. b) Each facility shall: 1) Maintain the building in good repair, safe and free of the following: cracks in floors, walls, or ceilings; peeling wallpaper or paint; warped or loose boards; warped, broken, loose, or cracked floor covering, such as tile or linoleum; loose handrails or railings; loose or broken windowpanes; and any other similar hazards. (B) 2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems. (A, B) 10) Protect the potable water supply from contamination by providing and properly installing adequate, backflow protection devices or providing adequate air gaps on	S9999		

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S9999	Continued from page 5 all fixtures that may be subject to backflow or back siphonage. These REQUIREMENTS are not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure hallway railings were secured in place along the walls in the A and B Wings Hallway; and failed to ensure its water system did not back flow from base of toilets to floors in resident rooms, onto the A and B Wings Hallway floor, and onto the shower/toilet room located on the A and B Wings Hallway. These failures have has the potential to affect all 44 residents residing at the facility. Findings include: The facility's (State) Ombudsman Program Residents' Rights for People in Long Term Care Facilities, Dated 11/2018, documents, "Your rights to safety: Your facility must be safe, clean, comfortable and homelike;" and "Your facility must provide services to keep your physical and mental health, at their highest practical levels." The facility's Resident Roster List, Dated 9/2/25, documents 44 residents reside in the facility. On 9/2/25 at 10:25am, three long hand railings located along the walls on the A and B Wings near the Nursing Station were loose, and holes were noted in the walls where the secure bolts for the railings had dislodged from the walls. On 9/2/25 at 10:25am, V8 Maintenance Director confirmed that the hand railings were loose and there were holes in the walls. V8 stated that he was unaware that the railings were loose prior to this date and stated that the railings should be fixed and secured. On 9/2/25 at 10:54am, a pool of water was seen on the bathroom floor of an unoccupied resident's room on the facility's A Wing. A small amount of water had spilled out onto the floor of the room. At this same time, V12 and V13 Certified Nursing Assistants/CNAs were working on the A wing and stated that the sewer backed up; stated that this has happened before and the water would spill out from underneath the toilets in some rooms. V12 stated that this was the second time within a year that backflow of water has happened.	S9999		

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S9999	Continued from page 6 On 9/2/25 at 11:15am, V8 Maintenance Director stated that he was waiting for a contractor to come and repair the second pump in the facility's septic pit; stated that only one pump was operable at this time and that two pumps were needed for pumping the water to make sure the water does not back flow. On 9/2/25 at 11:45am, the Shower Room (with a toilet) across from the A and B Wings Nursing Station had a pool of water on the floor. Staff stated that the Shower Room was not used by residents. At this same time, V8 Maintenance Director stated that the drain in the Shower Room seeped water when the septic pit pump is not adequate enough to make sure the water does not back flow. On 9/3/25 at 9:50am, V14 Housekeeping stated that there was water again in the resident's room on the A Wing; stated that it came from the base of the toilet and she mopped it up this morning. V14 stated that there was also a pool of water in R11's room on the B Wing; and stated that the water had seeped from beneath the base of the toilet. On 9/3/25 at 10:00am, V13 CNA stated that R8 is incontinent and does use the Shower Room's toilet all the time; stated that R8 is the only one who goes in to use the toilet but he is not supposed to but he does. On 9/3/25 at 10:03am, R11 stated that the water on her toilet floor "Just happened recently, started last night; they cleaned the water up before I used the toilet; and I hope we don't have any more of that; when it happens it happens." On 9/3/25 at 9:00am, the Shower Room had a large amount of water covering the floor of the shower as well as the toilet area in the shower. The water leaked out from beneath the Shower Room door and spilled out into the hallway across from the nursing station on the A and B Wings. At this same time, V8 Maintenance Director stated the water came from the Shower Room drain; stated that he had not had time to have this taken care of; and stated that at this time, he would take care of the water that had leaked out into the hallway. On 9/3/25 at 2:00pm, R8 stated that he does use the	S9999		

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S9999	Continued from page 7 toilet located in the Shower Room on the A and B Wings. R8 stated, “I use it all the time; but I won’t use it if you don’t want me to use it. There was water on the floor this morning; I was careful.” On 9/5/25 at 8:50am, R8 used his wheeled walker to ambulate into the Shower Room across from the nursing station on the A and B Wings. There were no posted signs to keep residents from entering the room; no wet floor signs; and the door was unlocked. A pool of water was noted on the floor as well as blankets for soaking up the water. V9 Licensed Practical Nurse/LPN and V15 Certified Nursing Assistant/CNA were near the nursing station and did not approach R8 until asked if R8 should be allowed entry into the Shower Room, at which time they redirected R8. R8 stated, “I am sorry.” R8’s Minimum Data Set (MDS) dated 9/1/25 documents R8 has a BIMS (Brief Interview of Mental Status) score of 7. (MDS indicates that on a scale of 0 – 15, 13 to 15 cognitively intact; 8 to 12 moderate impairment; and 0 to 7 severe impairment.) On 9/5/25 at 9:03am, V8 Maintenance Director stated that the Shower Room was mostly unused so V8 did not secure the door closed so that residents could not enter. V8 stated that residents “Did not use the shower in the Shower Room; and have not had any issues before right now.” On 9/5/25 at 9:05am, V15 CNA stated, “(R8) goes in there (Shower Room) all the time.” (B)	S9999		