

Illinois State Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                         |  |                                                                                                    |                                                                                                                          |                                                 |                            |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>3000376</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                               |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><b>01/20/2026</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><b>ARCADIA CARE HAVANA</b>   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                         |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>609 NORTH HARPHAM STREET , HAVANA, Illinois, 62644</b> |                                                                                                                          |                                                 |                            |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                         |  | ID<br>PREFIX<br>TAG                                                                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                 | (X5)<br>COMPLETION<br>DATE |
| S0000                                                        | Initial Comments<br><br>Complaint Investigation 2620245/2710789 -300.690)<br>300.690b) and 300.690c) cited.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                         |  | S0000                                                                                              |                                                                                                                          |                                                 |                            |
| S9999                                                        | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.690b)<br><br>300.690c)<br><br>Section 300.690 Incidents and Accidents<br><br>b) The facility shall notify the Department of any<br>serious incident or accident. For purposes of this<br>Section, "serious" means any incident or accident that<br>causes physical harm or injury to a resident.<br><br>c) The facility shall, by fax or phone, notify the<br>Regional Office within 24 hours after each reportable<br>incident or accident. If a reportable incident or<br>accident results in the death of a resident, the<br>facility shall, after contacting local law enforcement<br>pursuant to Section 300.695, notify the Regional Office<br>by phone only. For the purposes of this Section,<br>"notify the Regional Office by phone only" means talk<br>with a Department representative who confirms over the<br>phone that the requirement to notify the Regional<br>Office by phone has been met. If the facility is unable<br>to contact the Regional Office, it shall notify the<br>Department's toll-free complaint registry hotline. The<br>facility shall send a narrative summary of each<br>reportable accident or incident to the Department<br>within seven days after the occurrence.<br><br>These requirements were not met as evidenced by:<br><br>Based on record review and interview the facility<br>failed to report a fall with major physical injury to<br>the State Agency within 24 hours for one of three<br>residents (R1) reviewed for falls in the sample of 26.<br><br>Findings include:<br><br>The facility's Incident and Accidents policy dated |                                                                         |  | S9999                                                                                              |                                                                                                                          |                                                 |                            |

Office of Primary Care and Health Systems Management

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

Illinois State Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                         |  |                                                                                                    |                                                                                                                          |                                                 |                            |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>3000376</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                               |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><b>01/20/2026</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><b>ARCADIA CARE HAVANA</b>   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                         |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>609 NORTH HARPHAM STREET , HAVANA, Illinois, 62644</b> |                                                                                                                          |                                                 |                            |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                         |  | ID<br>PREFIX<br>TAG                                                                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                 | (X5)<br>COMPLETION<br>DATE |
| S9999                                                        | <p>Continued from page 1<br/>12/25 documents, "The Director of Nursing, Assistant Director of Nursing, or Nursing Supervisor must notify the following if an actual injury occurs: The Illinois Department of Public Health, via email, or phone within twenty-four hours of the occurrence."</p> <p>R1's Progress Notes dated 11/28/25 document R1 was observed lying on his right side in the hallway with complaints of pain to the right hip, right arm, and back and a laceration to the right elbow and was sent to the emergency room for treatment.</p> <p>The facility's (Name of State Agency) Investigations dated 11/1/25 through 1/15/26 were reviewed and do not include documentation of local State Agency being notified of R1's 11/28/25 fall with major injury.</p> <p>On 1/16/26 at 5:20 AM V2 (Director of Nursing) stated, "I was told by (V26/Regional Nurse) that I did not have to report (R1's) 11/28/25 fall with injury to (State Agency), so I did not report it."</p> <p>(C)</p> |                                                                         |  | S9999                                                                                              |                                                                                                                          |                                                 |                            |