

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/02/2016
FORM APPROVED
OMB NO. 0938-0391

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|--|---|--|--|---|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145774 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 07/27/2016 | |
| NAME OF PROVIDER OR SUPPLIER HAVANA HEALTH CARE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH HARPHAM STREET HAVANA, IL 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 |
| F 000 | INITIAL COMMENTS | | | F 000 | | | |
| F 226 SS=C | <p>Original investigation of complaint# 1624132/IL87205</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and observation the facility failed to follow the facility's Abuse Prevention Program by not having contact information posted for the Administrator. This has the potential to affect all residents.</p> <p>Findings include:</p> <p>The "Abuse Prevention Program" policy revised 11/11/11 documents, in part, " Employees are required to immediately report any occurrences of potential /alleged mistreatment , neglect and abuse of residents....to a supervisor and the administrator."</p> <p>On 7/27/2016 at 1:30 E5 Certified Nurse Aide (CNA) stated she would report abuse to the nurse or the Director of Nursing (DON). E4 CNA stated she would call the Administrator whose number is available at the nurses station. At 1:45PM E6 CNA stated she would report abuse to the E3 DON and then E1 Administrator. At 1:50PM E3 DON stated the staff reports to me then I report</p> | | | F 226 | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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| F 226 | <p>Continued From page 1 the allegation to (E1).</p> <p>On 7/27/2016 at 2:00PM E3 provided a list of phone numbers for Department Managers. E2 Assistant Administrator was listed as "Administrator" on the list however E1's number is not on this list. E3 went to each Nurses station to provide the posting of E1's phone number for staff to notify of abuse. E3 was unable to find the posting.</p> <p>The Facility Data Sheet completed on 7/27/2016 by E12, Registered Nurse, documents E1 as the administrator with a license number and E2 as the "Assistant Administrator" without a license number.</p> <p>The Facility Data Sheet completed 7/27/2016 by E12 documents the resident census as 61 residents.</p> | F 226 | | | |