STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145774	A. BUILDING _____ B. WING _____	C 07/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVANA HEALTH CARE CENTER	**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 Original investigation of complaint# 1624132/IL87205	F 000		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 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. Findings include: 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." 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	F 226		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 226	Continued From page 1 the allegation to (E1). 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. 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. The Facility Data Sheet completed 7/27/2016 by E12 documents the resident census as 61 residents.	F 226		