

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145538	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2026
NAME OF PROVIDER OR SUPPLIER Beecher Manor Nrsg & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Dixie Highway Beecher, IL 60401	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure privacy for 1 of 4 residents (R2) reviewed for personal privacy. This failure resulted in R2 feeling unsafe in the facility. The findings include: R2's EMR (Electronic Medical Record) showed R2 was admitted to the facility on [DATE], and discharged on April 07, 2026. R2 had multiple diagnoses including, radiculopathy, osseous and subluxation stenosis of intervertebral foramina of lumbar region, spondylosis with radiculopathy in the lumbar region, spinal stenosis, difficulty in walking, lack of coordination, abnormal posture, reduced mobility, muscle wasting and atrophy, hyperlipidemia, depression, anxiety, hypertensive chronic kidney disease, atrial fibrillation, spinal stenosis and low back pain. R2's MDS (Minimum Data Set) dated March 18, 2026 showed R2 was cognitively intact and required supervision or touching assistance for toileting and transfers. R2's most recent care plan showed that R2 refused to use the restroom in the resident's room. R2 utilized a bedside commode instead. On March 27, 2026 R2 filed a grievance with social services and informed V3 (Social Services Director) that a man entered her room while her pants were down and no one knew who the man was. On May 02, 2026, at 10:30AM R2 said that an African American man from the outside entered into the facility and was brought down to her room by the nurse while she was using the commode. R2 said that the individual was not an employee and did not knock or introduce himself. R2 said that the individual told her that he was coming to ask her about her stay in the facility while she was still sitting on the commode. R2 asked the gentleman and V9 (RN/Registered Nurse) to come back later as she was not available at the moment. R2 said V9 and the gentleman remained in the room and kept telling her that he only wanted to ask her a few questions. R2 said that she felt her privacy was violated as she was forced to answer questions while sitting on the commode. R2 said that V3 attempted to find out who the gentleman was and questioned V9 but was unable to determine who the individual was. R2 said that she requested a room change later that day. R2 said that she had only just recently heard from V1 (administrator) regarding the situation a few days ago and there was no resolution to the concern when she was still residing in the facility. On May 02, 2026, at 12:16PM V9 said that a gentleman informed her that he needed to interview her about R2. V9 informed the gentleman that R2 was alert and oriented and able to answer any questions he may have. V9 said she walked the gentleman to R2's room and believed R2 to be sitting in a wheelchair. V9 said she left the gentleman in the room with R2. On May 02, 2026, at 12:59AM, V1 (Administrator) said she was aware of the incident that occurred with R2. V1 said that grievances are discussed during morning standup. V1 said that when she heard about the issue, she assumed it was maintenance that entered the room and informed maintenance to knock before entering the room. V1 said that the facility's policy is that the receptionist at the front desk should ensure that everyone has signed in via the electronic kiosk before moving around the building. V1 confirmed that resident's privacy should be respected, and people should knock before entering rooms and respect a resident's choice to be seen later if requested. V1 confirmed that R2's privacy was not maintained.		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that a residents nutritional needs were met. This applies to 1 resident (R1) reviewed for significant weight loss in the sample of 9. The findings include: R1's electronic medical record (EMR) showed R1 was admitted to the facility on [DATE], and discharged from the facility on February 15, 2026. R1 had multiple diagnoses including fracture of the left femur, sepsis, difficulty walking, moderate protein calorie malnutrition, dysphagia, hemiplegia, type II diabetes, lack of coordination, dementia, pain, reduced mobility, epilepsy, cerebral ischemic attack, polyneuropathy, hypertension, osteoarthritis, spondylosis, and falls. R1's minimum data set (MDS) dated [DATE], showed R1 had severe cognitive impairment and required maximal assistance from staff for eating and oral hygiene. R1's most recent care plan showed R1 had a potential nutritional problem and was receiving a therapeutic and mechanically altered diet. Staff were to monitor, record, and report to physician any signs and symptoms of malnutrition including significant weight loss. The registered dietitian was to evaluate and make diet change recommendations as needed. R1's physician's orders showed, R1 was on a low concentrated sweets, pureed texture diet with honey thickened liquids and required one to one feeding assistance. However, a nursing progress note entered on February 13, 2026, showed R1 was a partial self-feed, despite R1's order for one-to-one feeding assistance. R1's electronic medical record showed R1 weighed 121 pounds on January 16, 2026, and 108 pounds on February 05, 2026. R1 was last seen by the dietitian on January 20, 2026. R1 was seen by the nurse practitioner on February 13, 2026, and R1's weight loss was not addressed during the visit. There were no additional dietitian notes in R1's chart and no new dietary recommendation orders since R1's weight loss in February. On April 30, 2026, at 5:39PM, V16 (Family Member) said that he came to the facility often because the staff were not feeding R1 and that the amount of food given was not enough for a single person to eat. V16 said that when he brought in items for R1 to eat he would get yelled at. V16 said that he came quite often and began to perform most of the care on his own because staff were not providing care for R1. V16 said R1 had a fall in mid-February and was sent to the hospital. V16 said it was during this time that he learned that R1 had gone from 121 pounds down to 100 pounds in less than one month. On May 02, 2026, at 1:38PM, V10 (LPN/Licensed Practical Nurse) said that V16 was not compliant with R1's specialized diet and would often bring in additional food for R1 to eat despite being educated not to. V10 said she was not aware of R1's weight loss. On May 02, 2026, at 12:45PM, V2 (Director of Nursing) said she was unaware of R1's weight loss and had not been notified. V2 said that she had only just started working at the facility during this time and was still getting to know the residents. V2 said that R1 should have been followed by the dietitian and confirmed that no additional orders had been placed to address R1's significant weight loss. V1 was asked to provide the contact information for the dietician, but V1 never provided the requested information. The facility's policy Nutrition (Impaired)/Unplanned Weight Loss-Clinical Protocol showed Assessment: 4. The staff will notify family of significant weight gains or losses or any abrupt or persistent decline from baseline appetite or food intake. Treatment: 2. The physician and or designee will authorize appropriate general or cause-specific interventions. Monitoring: 1. The physician and staff will monitor nutritional status, response to interventions, and possible complications of such interventions of individuals with impaired nutritional status.		