

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

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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 07/16/2026
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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was free from exploitation and sexual abuse by V5 (Maintenance Assistant). This applies to 1 resident (R1) reviewed for abuse in a sample of 5 residents. V5's abuse of power and manipulation resulted in mental anguish for R1. The findings include: On 7/15/26 at 11:04 AM, V7 (CNA/Certified Nurse Assistant) stated on 7/12/26 around 8:50 AM she walked into R1's room to deliver her breakfast tray and she saw V5 (Maintenance Assistant) and R1 kissing behind R1's door. V7 said that as she walked into R1's room and looked to her left, she saw R1 and V5's lips touching at the end of a kiss. V7 said R1's hands were on V5's neck/shoulders and R1's back was towards V7. V7 said V5's eyes were initially closed and when the kiss ended, as he opened his eyes. V7 stated when V5 saw V7 there, his eyes became wide and big. V7 said she did not think R1 knew V7 saw her kissing V5 because R1's back was towards V7 and R1 is blind. V7 said she left R1's room after V5 left and V5 approached her in the hall. V7 stated V5 told her R1 said she loved him and wanted to be with him. On 7/16/26 at 10:22 AM, V5 (Maintenance Assistant) stated R1 would wait outside her room in the hallway for V5 in the mornings and he would go right up to her face (because she is blind) and say something like boogey boogey and R1 would say she knew he was there because she could feel him. V5 said R1 would do her dance moves and he would say to her shake your booty. V5 said R1 had told him she loved him and she wanted V5 to take her out of the facility on the weekends. V5 said he told R1 he could not sign her out of the facility because then people would be looking at them and asking questions. V5 said he knew kissing R1 was wrong because he is an employee of the facility and she is a resident. V5 said after V1 (Administrator) was made aware V5 was seen kissing R1, V1 spoke to him on the phone and told him to leave the facility but he did not leave the facility right away and instead went back to check on R1 because he cares about R1. V5 said R1 kept telling him she wanted him and V5 asked R1 what she meant by that and R1 told V5 she wanted his body. V5 said on 7/12/26, R1 told him the resident in the adjacent room was sleeping and asked V5 to go into her room. V5 said he entered R1's room and went behind the door and R1 followed him, hugged him, and put her mouth up towards him and he kissed her. V5 said his hands were on R1's waist and his eyes were closed while he was kissing R1. V5 said V7 (CNA) walked into R1's room and saw him kissing R1. V5 said V7 looked startled, and he told her Shh because he didn't want her to say anything about what she saw. V5 said after he left R1's room, he approached V7 and told her R1 was in love with him. V5 said he could not recall having any abuse training and he didn't think that would pertain to him. On 7/16/26 at 12:27 PM, V4 (Maintenance Director) said a staff member kissing a resident is sexual abuse and V5 went over the line. V4 said he reviewed the facility camera footage on 7/13/26, the day after V5 was seen kissing R1. V4 said the footage showed V5 and R1 in the hallway outside R1's room, then V5 walked into R1's room for a (continued on next page)		

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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