STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145857	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven of St. Elmo	221 East Cumberland St Elmo, IL 62458

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 - Minimal harm or potential for actual harm Residents Affected - Few	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 residents were free from resident to resident sexual and physical abuse for 3 of 3 residents (R1, R2 and R3) reviewed for abuse in the sample of 6. Findings include:1. The Facility's Final Reportable Event dated 4/16/2026 documented in part: R2 an [AGE] year-old female with a BIMS (Brief Interview for Mental Status) score of 5 and a diagnosis of Alzheimer's disease was observed engaging in inappropriate sexual behavior of an oral nature with R1 a [AGE] year-old male with a BIMS score of 2 and a diagnosis of dementia. Upon discovery, staff immediately intervened and separated both residents. There was no evidence of force, coercion, threat, or distress observed in either resident at the time of the incident. Investigation confirmed R1 and R2 had an established friendly relationship and had not previously demonstrated sexually inappropriate behavior. Based on the findings this incident is not substantiated as willful abuse.R1's admission Record documented an admission date of 8/04/2025 and included diagnoses of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R1's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 12, which indicates moderate cognitive impairment. R1's Care Plan had a focus area documented of R1 is at risk for abuse due to dementia that included reporting all instances of alleged abuse to the abuse coordinator. R1's Progress Note dated 4/8/2026 at 5:49 PM by V6 (Registered Nurse/RN) was lined out for incomplete documentation but included: Res (resident) found in female res room with his penis in her mouth. Res separated and this res sat in DR (dining room) with staff. No adverse effects noted. This note had a strike out date of 4/10/2026 at 9:04 AM. R1's Progress Note dated 4/8/2026 at 5:49 PM by V6 (RN) documented Late Entry: Res found in female res room. Res separated and this res set in DR with staff. No adverse side effects noted.R2's admission Record documented an admission date of 1/16/2026 and included diagnoses of Alzheimer's disease, unspecified, anxiety, dementia in other disease classified elsewhere, without unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R2's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 5, which indicates severe cognitive impairment. R2's Care Plan had a focus area documented of R2's has the diagnosis of dementia and is noted to have impaired cognitive function and behavioral complications. Interventions that included monitor for and report to the nurse any noted changes in R2's cognitive function such as: changes in her decision making ability, memory, recall, general awareness, difficulty expressing herself, difficulty understanding others, changes in level of consciousness or mental status. R2's Progress Note dated 4/8/2026 at 6:05 PM by V6 (RN-Registered Nurse) was lined out for incomplete documentation but included: at 5:49 PM, CNA (Certified Nursing Assistant) noted male res (resident) in this res room. His penis was in her mouth. Res separated with this res becoming upset and hit CNA. Res then came out of room. Attempted to go out locked unit door. When she couldn't get out the door she called this nurse a son of a b***h and hit her in the jaw. Res then went to room and did not come out. This note had a strike out date of 4/9/2026 at 10:28 AM. R2's Progress Note dated 4/8/2026 at 6:05 PM by V6 documented Late Entry: at 5:49 PM CNA noted (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145857	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven of St. Elmo	221 East Cumberland St Elmo, IL 62458

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 - Minimal harm or potential for actual harm Residents Affected - Few	male res in this res room. Res separated with this res becoming upset and hit CNA. Res then came out of room. Attempted to go out locked unit door. When she couldn't get out the door she called this nurse a son of a b***h and hit her in the jaw. Res then went to room and did not come out.On 4/21/2026 at 12:53 PM, when R1 was asked about an incident with him and R2, R1 stated he had never participated or seen any inappropriate behavior and does not even know who R2 is.On 4/21/2026 at 12:56PM, when R2 was asked about an incident between her and R1, R2 stated she had not witnessed or participated in any inappropriate behavior and does not remember anyone coming into her room with her.On 4/21/2026 at 1:18 PM, V11 (Certified Nursing Assistant/CNA) stated she had been sitting at the dining room table charting after dinner on 4/8/2026 when V13 (Dietary Aide) asked her if it was normal for R1 and R2 to walk off together. V11 stated, she got up to go see where R1 and R2 went because they have been known to exit seek. V11 stated, when she walked out of the dining room, she noticed R2's door was shut. V11 stated, when she opened R2's door, R2 was sitting on her bed with R1 standing in front of her with his pants down and her mouth on his penis. V11 stated, she immediately asked R1 and R2 to stop with R1 pulling up his pants and R2 started growling at her. V11 stated, R1 went out to the dining room with her and R2 stayed in her room. V11 stated, she did report the incident to V6 (RN). On 4/21/2026 at 2:46 PM, V13 (Dietary Aide) stated she had been sitting with residents on the secured unit in the dining room. V13 stated, R1 and R2 had been sitting in the dining room and had been talking. V13 stated, she noticed R1 and R2 walked off together and went to R2's room and she noticed they shut the door so she notified V11 (CNA) that R1 and R2 should not be doing that. V13 stated, V11 went straight to R2's room and when she opened the door. V11 told both residents to stop. V13 stated, R1 went to dining room to sit while V6 (Registered Nurse) went to assess R2 and R1, then called both families. On 4/22/2026 at 9:33 AM, V6 (RN) stated, she had been working on 4/8/2026 when she overheard V11 (CNA) say stop, we don't do that here and separated R1 and R2. V6 immediately notified her of what she had witnessed between R1 and R2. V6 stated, she went to assess R2. V6 stated, R2 was upset that V11 separated her and R2. V6 stated, R2 started to walk towards the door, turned around and slapped her. V6 stated, R2 then when back to her room. On 4/22/2026 at 11:12 AM, V1 (Vice President of Operations) stated, it is her expectation all staff follow the facility's policies and procedures. V1 stated, the facility had completed a reassessment of R1's BIMS score and he is severe cognitively impaired.3. R3's admission Record documented an admission date of 8/28/2025 and included diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, other muscle spasm, depression, unspecified, anxiety disorder and bipolar II disorder. R3's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicates R3 is cognitively intact. R3's Care Plan documented a focus area of R3 is at risk for abuse due to stroke with interventions that included report all instances of alleged abuse to the abuse coordinator.On 4/21/2026 at 12:47 PM, R3 stated R1 did come into his room last week on 4/13/2026, slammed his door and when he asked R1 to open his door back up, R1 slapped him across the face. R3 stated, he reported the incident to V18 (Licensed Practical Nurse/LPN) and V19 (Certified Nursing Assistant/CNA) they removed R1 from his room. On 4/22/2026 at 3:58 PM, V19 (Certified Nurse Assistant/CNA) stated, she did work the evening R1 and R3 had an altercation. V19 stated, she had been down the hallway assisting another resident when she noticed R1 entering R3's room. V19 stated, she started down the hallway and attempted to redirect R1 out of R3's room. V19 stated, before she got to R3's room, R1 had slammed the door and she did hear R3 yell, Hey. V19 stated, by the time she opened the door, R1 and R3 were separated with R3 saying R1 just slapped him and R1 holding his hand and rubbing it. V19 stated, R1 was saying something about he can't tell me to leave the bathroom. V19 stated, the hallway bathroom is across from R3's room so she believes R1 had gotten confused about which door he went in to use the bathroom. V19 stated, she did notify V18 (LPN-Licensed Practical Nurse) of the incident and R3 told V19 the same story he told her. R1's Progress Note dated 4/13/2026 at 7:02 PM by V18 (LPN) documented R1 had been up walking about the facility. R1 entered another male resident room and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145857	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven of St. Elmo	221 East Cumberland St Elmo, IL 62458

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 - Minimal harm or potential for actual harm Residents Affected - Few	slams the door shut behind him. Staff had been alerted and observed R1 standing in another resident room yelling out and R3 stated that R1 had stricken him in the face. V19 (CNA) was able to redirect R1 out of R3's room and offered a snack and drink. R1 is currently sitting in dining room, awaiting new orders. Will continue to keep close observation and encourage R1 to stay out of other residents room without their permission. R3 had no documentation in his electronic health record about the physical altercation between him and R1. On 4/22/2026 at 11:12 AM, V1 (Vice President of Operations) stated, it is her expectation all staff follow the facility's policies and procedures. V1 stated, the facility had completed a reassessment of R1's BIMS score and he is severe cognitively impaired.The Facility's Final Reportable Event dated 4/20/2026 documented an investigation that had been completed into the physical altercation between R1 and R3 that occurred on 4/13/2026. The facility's Abuse Prevention Policy (undated) documented this facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, deprivation of goods and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and mistreatment of residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145857	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven of St. Elmo	221 East Cumberland St Elmo, IL 62458

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report allegations of sexual abuse and physical abuse to the administrator immediately for 2 (R1 and R3) of 3 residents reviewed for abuse in the sample of 6. Findings included:1. R1's Progress Note dated 4/8/2026 at 5:49 PM by V6 (Registered Nurse/RN) was lined out for incomplete documentation but included: Res (resident) found in female res room with his penis in her mouth. Res separated and this res sat in DR (dining room) with staff. No adverse effects noted. This note had a strike out date of 4/10/2026 at 9:04 AM. On 4/22/2026 at 11:12 AM, V1 (Vice President of Operations) stated, she received an email on 4/9/2026 from V3 (Director of Nursing/DON) notifying her of the interaction between R1 and R2 the evening before. V1 stated, V2 did communicate in the email that R1 and R2 had been in R2's room, when V11 walked in and found R2 sitting on the bed with R1 standing in front of her with his pants down and R2 having her lips on R1's penis. 2. R1's Progress Note dated 4/13/2026 at 7:02 PM by V18 (Licensed Practical Nurse/LPN) documented R1 had been up walking about the facility. R1 entered another male resident room and slams the door shut behind him. Staff had been alerted and observed R1 standing in another resident room yelling out and R3 stated that R1 had stricken him in the face. V19 (Certified Nursing Assistant/CNA) was able to redirect R1 out of R3's room and offered a snack and drink. R1 is currently sitting in dining room, awaiting new orders. Will continue to keep close observation and encourage R1 to stay out of other residents room without their permission. On 4/21/2026 at 12:47 PM, R3 who was alert to person, place and time stated, R1 did come into his room last week on 4/13/2026, slammed his door and when he asked R1 to open his door back up, R1 slapped him across the face. R3 stated, he reported the incident to V18 (LPN), and they removed R1 from his room. On 4/22/2026 at 12:06 PM, V16 (Licensed Practical Nurse/LPN) stated, she had been made aware of the physical altercation between R1 and R3 on 4/14/2026 when she came in that morning. V16 stated, she had been notified by V17 (Registered Nurse/RN) that R3 stated R1 had gone into his room, slammed his door and struck him on the evening of 4/13/2026. V16 stated, V1 had not been notified until 4/14/2026 about the altercation and that is when the investigation started. On 4/22/2026 at 12:15 PM, V3 (Director of Nursing/DON) stated, she had been contacted the evening of 4/13/2026 by V17 (RN) notifying her that R1 went into R3's room and slammed his door. V3 stated, no one reported to her of R1 hitting R3 at that time. On 4/22/2026 at 12:54 PM, V1 stated she was notified by V16 via email on 4/14/2026 that R1 and R3 had an alleged physical altercation that took place in the evening before on 4/13/2026. R1's Progress Note dated 4/14/2026 at 9:48 AM by V16 (LPN) documented 7:56 AM V3 (DON) updated on incident, 8:06 AM V1 notified of incident, 8:16 AM family notified of incident, 8:40 local police department called and awaiting call back.The facility's Abuse Prevention Policy (undated) documented Under Procedures: V. Internal Reporting Requirements and Identification of Allegations, Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145857	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven of St. Elmo	221 East Cumberland St Elmo, IL 62458

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to thoroughly investigate an allegation of physical abuse for 1 (R3) of 3 residents reviewed for abuse in the sample of 6. Findings include: R1's Progress Note dated 4/13/2026 at 7:02 PM by V18 (Licensed Practical Nurse/LPN) documented R1 had been up walking about the facility. R1 entered another male resident room and slams the door shut behind him. Staff had been alerted and observed R1 standing in another resident room yelling out and R3 stated that R1 had stricken him in the face. V19 (Certified Nursing Assistant/CNA) was able to redirect R1 out of R3's room and offered a snack and drink. R1 is currently sitting in dining room, awaiting new orders. Will continue to keep close observation and encourage R1 to stay out of other residents room without their permission. On 4/21/2026 at 12:47 PM, R3 who was alert to person, place and time, stated R1 did come into his room last week on 4/13/2026, slammed his door and when he asked R1 to open his door back up, R1 slapped him across the face. R3 stated, he reported the incident to V18 (LPN) and V19 (CNA) and they removed R1 from his room.On 4/22/2026 at 3:58 PM, V19 (Certified Nurse Assistant/CNA) stated, she did work the evening R1 and R3 had an altercation. V19 stated, she had been down the hallway assisting another resident when she noticed R1 entering R3's room. V19 stated, she started down the hallway and attempted to redirect R1 out of R3's room. V19 stated, before she got to R3's room, R1 had slammed the door and she did hear R3 yell, Hey. V19 stated, by the time she opened the door, R1 and R3 were separated with R3 saying R1 just slapped him and R1 holding his hand and rubbing it. V19 stated, R1 was saying something about he can't tell me to leave the bathroom. V19 stated, the hallway bathroom is across from R3's room so she believes R1 had gotten confused about which door he went in to use the bathroom. V19 stated, she did notify V18 (LPN) of the incident and R3 told V19 the same story he told her. V19 stated, she had not received any in-services from V3 (Director of Nursing/DON) on 4/9/2026 and she did not get questioned or asked to write a statement for the physical altercation between R1 and R3 on 4/13/2026 from the facility.On 4/23/2026 at 9:18 AM, V3 (DON) stated V18 (LPN) and V19 (CNA) did not come to the first in-services dated 4/9/2026 and she did not follow up with them to review the in-services. V3 stated, the investigation for R1 and R3's physical altercation had been sent in its entirety to her knowledge to surveyor. V3 stated, she had not been asked by V1 to gather statements from V18 or V19 on the physical altercation dated 4/13/2026. On 4/23/2026 at 9:26 AM, V1 (Vice President of Operations) stated it is her understanding that all documents for R1 and R3's physical altercation had been sent from the facility to the surveyor. V1 stated, she believed per V16 (LPN) that V18 (LPN) had been in-serviced on 4/9/2026. V1 stated, she was unaware of V19 (CNA) being present during R1 and R3's altercation and does not have a statement from V19. V1 stated, she used V18's progress note dated on 4/13/2026 as her statement. The facility provided no documentation on V19's statement of the physical altercation that took place on 4/13/2026 or In-service sheets with V18's (LPN) or V19's (CNA) signature on them for the 4/9/2026 in-services given by V3 (DON). On 4/22/2026 at 12:24 PM a message was left for V18 (LPN) via telephone with no returned call. On 4/23/2026 at 8:02 AM, 8:12 AM and 1:55 PM left messages for V18 (LPN) via telephone with no returned call. The facility's Abuse Prevention Policy (undated) documented Under Procedures: VII. Internal Investigation: 4. Investigation Procedures. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed.