STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145948	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven of Bement.	601 North Morgan Bement, IL 61813

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 an allegation of misappropriation of medication for one resident (R1) of three residents reviewed for medications in the sample list of four. Findings include: On 11/19/24 at 11:25 AM, V3 Licensed Practical Nurse (LPN) stated V3 told V1 Administrator right after V3 saw R1's medications crushed in the garbage on 11/12/24 when V3 came in for 10 PM shift. V3 stated the second shift nurse was still passing medications when V3 came in for 3rd shift. V3 stated V6 agency nurse told V3 that V6 could not find the adapter for R1's gastrostomy tube (g-tube), that V6 has lost it. V3 stated V3 found a new adapter in the medication cart and that is when V3 saw the crushed medications in the garbage with R1's name on the little med cup. V3 stated all the medications in that little medication cup were crushed and they were white and pink. V3 stated she was going to take it out of the trash but went to do something first and when V3 returned to the cart, V6 had taken the trash bag already. V3 stated that's when she texted V1 Administrator to tell V1 because there in no Director of Nursing (DON) here. V3 stated V1 never answered the text and never asked V3 anything about the medications V3 had found. V3 stated V3 does not know who the nurse was and she did not have a name badge on but V3 had never seen her here before. On 11/19/24 at 11:49 AM, V1 Administrator stated V1 did not do any type of report about this incident. The facility's Abuse Prevention Program Policy dated Revised 11/28/2016, documents once the Administrator receives an allegation of misappropriation of resident property, the administrator will appoint a person to take charge of the investigation and this person will follow the Resident Protection Instigation Procedures, and the Administrator will keep the resident or resident representative informed of the progress of the investigation. This same policy documents the administrator or designee is then responsible for forwarding a final written report of the results of the investigation to the Department of Public Health within five working days of the reported incident.

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 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 investigate a report of misappropriation of resident medication for one resident (R1) of three residents reviewed for medications in the sample list of four. Findings include: On 11/19/24 at 11:25 AM, V3 Licensed Practical Nurse (LPN) stated V3 told V1 administrator right after V3 saw R1's crushed medications in the garbage on 11/12/24 when V3 came in for V3's 10 PM shift. On 11/19/24 at 11:49 AM, V1 Administrator stated V1 did not follow up in the morning and forgot about it until surveyor just mentioned it to V1. V1 also stated V1 did not interview anyone, call anyone or do any type of report or investigation about it (report of misappropriation of resident medication). The facility's Abuse Prevention Program Policy dated Revised 11/28/2016, documents regardless of the specific nature of the allegation, the investigation shall consist of: a review of the initial written reports, completion of a written report on the status of the investigation of the occurrence, an interview with the person reporting the incident, an interview with the resident, an interview with staff members having contact with the resident, interviews with other residents to which the accused has regular contact with, interview other employees to determine if they have ever witnessed incidents involving the accused, an interview with the accused, and a review of all circumstances surrounding the incident.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to administer seizure medications to a resident with a seizure disorder requiring scheduled therapeutic medication monitoring. This failure affects one resident (R1) of three residents reviewed for significant medication errors in the sample list of four. Findings include: R1's current Electronic Medical Record (EMR) Medical Diagnoses documents R1's diagnosis as: Localization-related (focal) (partial) Idiopathic Epilepsy and Epilectic Syndromes with Seizures of localized onset, intractable, without Status Epilepticus. R1's current EMR Physician Order Sheet (POS) dated November 2024, documents R1's medications as: Levetiracetam Oral Solution 100 milligram/milliliter MG/ML, give 15 ml via percutaneous endoscopic gastrostomy (PEG)-Tube two times a day and Carbamazepine Oral Tablet Chewable 100 MG, give 1 tablet via PEG-Tube in the evening. This same POS documents keppra, vimpat, tegretol level every 6 months one time a day every 6 month(s) starting on the 1st or 1 day(s) related to Localization (focal) (partial) Idiopathic Epilepsy and Epileptic Syndromes with seizures of localized onset, intractable, without status Epilepticus. On 11/19/24 at 11:25 AM, V3 Licensed Practical Nurse (LPN) stated V3 told V1 Administrator right after V3 saw the medications crushed in the garbage on 11/12/24 when V3 came in for 10 PM shift. V3 stated the second shift nurse was still passing medications when V3 came in for 3rd shift. V3 stated V6 agency nurse told V3 that V6 could not find the adapter for R1's g-tube (PEG tube), that V6 has lost it. V3 stated V3 found a new adapter in the medication cart and that is when V3 saw the crushed medications in the garbage with R1's name on the little med cup. V3 stated all the medications in that little medication cup were crushed and they were white and pink. V3 stated she was going to take it out of the trash but went to do something first and when V3 returned to the cart, V6 had taken the trash bag already. V3 stated that's when she texted V1 Administrator to tell V1 because there in no Director of Nursing (DON) here. V3 stated V1 never answered the text and never asked V3 anything about the medications V3 had found. V3 stated V3 does not know who the nurse was and she did not have a name badge on but V3 had never seen her here before. On 11/19/24 at 11:22 AM, V1 Administrator stated she does not remember anyone saying anything about medications being found in a trash can. On 11/19/24 at 11:49 AM, V1 Administrator stated V1 did did have a late night conversation on the phone about finding R1's medications in the trash. V1 stated the nurse that she conversed with was V3 LPN. V1 stated V3 told V1, V3 was on shift and found R1's medications in the trash. V1 stated V1 did not follow up in the morning and forgot about it until surveyor just mentioned it to V1. V1 stated V1 did not interview anyone, call anyone or do any type of report about it. V1 stated V3 works the night shift 10PM to 6AM so the nurse who would have worked on the evening shift on 11/12/24 would have been an agency nurse (V6). On 11/19/24 at 12:11 PM, V4 LPN (agency nurse been here about a year) stated V4 heard about the medications for R1 being found in the trash from V3 LPN because V3 had worked the night before (11/12/24) and V4 came in for day shift on 11/13/24. V4 stated V3 reported the incident verbally for shift report. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Adverse Drug Reactions and Medication Discrepancy Policy dated Reviewed 11/6/18, documents drug errors are to be reported to the resident's physician, documented in the nursing notes, and documented on a Medication Discrepancy Report. This policy also documents the report is to be completed in coordination with the Director of Nursing and filed with the Administrator, and reviewed by the medical director. This same policy documents to report medication discrepancy immediately to the attending physician for treatment options, continue assessment of resident per physician order, document a detailed account of the discrepancy in the resident's medical record, the form must be signed and forwarded to the Director of Nursing, and all medication discrepancies will be reported to the Quality Assurance Committee for review.