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	10/10/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain transport equipment in working order and failed to safely secure one resident (R1) by not applying a seatbelt properly during resident transport. R1 experienced pain and obtained two nasal fractures and six sutures after falling while being transported in the facility van. The facility failed to implement fall interventions and failed to determine root causes for four falls for one (R3) resident. These failures affected two (R1, R3) residents out of three residents reviewed for Accidents in a sample list of three residents.Findings include: 1. R1's Electronic Medical Record (EMR) documents R1's medical diagnoses as athetoid cerebral palsy, anemia, glaucoma, primary osteoarthritis, difficulty walking, acute-on-chronic heart failure, adjustment disorder with anxiety, bilateral astigmatism, bilateral myopia, bilateral presbyopia, restless-leg syndrome, and a history of myocardial infarction.R1's Minimum Data Set (MDS), dated [DATE], documents that R1 is cognitively intact. The same MDS notes that R1 is dependent on staff for transfers and transportation.R1's Care Plan intervention, dated 7/5/2024, directs staff to assist R1 in transferring to a wheelchair and to assist R1 in positioning for comfort during transfers and while up. It also instructs staff to help R1 achieve and maintain an upright posture and proper alignment, as possible, when out of bed.R1's Fall Risk Assessment, dated 6/23/25, classifies R1 as a high fall risk.R1's Physician Order Sheet (POS), dated October 2025, shows a physician's order, effective from 9/24/24 with no end date, to administer daily aspirin 81 mg (milligram).R1's Hospital Record, dated 9/22/25, indicates R1 was evaluated in the emergency room following a fall from his wheelchair while in the facility's transport van. The record reports that R1 sustained:A 4.0 cm (centimeter)x 4.0 cm forehead hematoma with mild bogginessA 1.0 cm linear partial-thickness laceration to the extraoral upper [NAME] moderate abrasion to the nasal dorsumA 0.5 cm linear full-thickness laceration to the right narisA 1.5 cm linear laceration to the upper labial mucosaIt further notes that R1 received suture repair on three lacerations under local anesthesia, and a pressure dressing was applied to the forehead hematoma.R1's CT scan of the maxillofacial region, dated 9/22/25, reveals a scalp hematoma involving the forehead and extending to the bridge of the nose and right medial canthus region, along with comminuted bilateral nasal bone fractures with slight displacement.R1's Fall Investigation, dated 9/22/25, documents that R1 had an unwitnessed fall in the facility van en route to a physician appointment. The investigation notes that R1 sustained: an abrasion to the top of the scalp; abrasion to the right elbow; an abrasion to the front of the right knee; an abrasion to the front of the left knee; facial bruising; a facial fracture; a nasal laceration; a skin tear to the back of the right hand; and a skin tear to the right forearm.R1's Nurse Progress Notes read:9/22/25, 6:31 PM: R1 left the facility at approximately 7:30 AM for a cardiology appointment and returned at 3:45 PM. The note states R1 fell during transport and was taken by ambulance to the emergency room. Upon return, R1 complained of a headache. The skin assessment found dime-size abrasions under the right knee, left knee, and right elbow; a skin tear to the right lower arm (unapproximated due to dried blood and skin); a dime-size abrasion on the top of the head; and bruising to both eyes and the nose. The note also reports six stitches on the right side/under the right side of the nose, with swelling to the right side of the face and eyes. It states: (R1's) elastic wrap is in place to forehead and, per hospital instructions, should not be removed for 24 hours due to swelling/hematoma of the forehead. Unable to assess the skin under the wrap. Swelling noted to right wrist/arm. (R1) states he was sitting up in his wheelchair in the transport van when, suddenly, he fell out, landing on his right side.9/22/25, 6:53 PM: R1 was seen in the emergency room and diagnosed with traumatic hematoma of the forehead, facial laceration, fall from wheelchair, cervical stenosis of the spinal canal, and closed nasal bone fractures.9/23/25, 11:59 AM: R1 declined a shower, stating his body was too sore from the fall on 9/22/25.R1's Provider Progress Note, dated 9/23/25 at 12:21 PM, states: (R1) is seen post fall/E.R. visit for broken nose. (R1) fell and hit his face due to van malfunction. (R1) has a mild headache and is using acetaminophen. (R1) has bruising on his face.The invoice report dated 9/26/25 for maintenance of the facility's transport van documents that the van lift inspection revealed: Missing some odds-and-ends hardware; adjusted handrail tension at stow; adjusted stow blocks; adjusted towers one and two; cleaned out floor tracks and locks on retractors.R1's final report to the State Agency, dated 9/29/25, states that R1 fell out of his wheelchair while being transported to a physician appointment on 9/22/25. The report notes that R1 was sent to the emergency room after the fall, which caused a laceration requiring six sutures to the right side of his nose and closed nasal fractures. It further documents that V3 Maintenance