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	01/21/2026

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify the physician and family of the resident with a change in condition (weight loss) for two (R1, R8) of three residents reviewed for weight loss. Findings include:The facility policy Lab, Diagnostic Test Results and Change in Resident's Condition - Clinical Protocol Dated November 2016 documents to establish guidelines for physician notifications concerning resident lab and diagnostic tests results and change(s) in resident conditions. The policy further documents 2: The person who is to communicate results to a physician will review, compile the information and be prepared to discuss the following: a. the individual's current condition and any recent changes in status, including vital signs and mental status.The facility's undated Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol documents 1. Monitor and document the weight and nutritional status of residents in a format which permits readily available month-to-month comparisons. 2. Assess the individual's current nutritional status and identify individuals with anorexia, recent weight loss, and significant risk for subsequently impaired nutrition. 4. The staff will notify family of significant weight gains or losses or any abrupt or persistent decline from baseline appetite or food intake.The policy further documents 1. The physician and/or designee will review possible causes of anorexia or weight loss with the nursing staff and/or dietitian before ordering interventions. a.: For individuals with recent or rapid weight loss (for example, more than a pound a day), the staff and physician should consider possible fluid and electrolyte imbalance as a cause. Monitoring: I. The physician and staff will monitor the nutritional status, response to interventions, and possible complications of such interventions (for example, aspiration, diarrhea, nausea, or vomiting) of individuals with impaired nutritional status.On 01/15/26 at 11:30am, R1's care plan documents an admission date of 11/25/2025 with diagnosis of Diabetes Mellitus Due to Underlying Condition with Diabetic Neuropathy, Unspecified (E08.40), and Other Lack of Coordination (R27.8).On 01/15/26 at 11:35am, R1's medical record review documents the following weights were obtained during R1's stay at the facility: admission weight: 11/25/2025 6:17pm 175.2 pounds (Lbs.) Wheelchair. 11/26/2025 1:25pm 170.4 Lbs. Mechanical Lift (Full Body), -4.8lbs (-3%) 11/27/2025 11:20am 157.1 Lbs. Mechanical Lift (Full Body), -13.3lbs (-8%) 12/05/2025 11:54am 163.6 Lbs. Mechanical Lift (Full Body), +6.5lbs (+4%) 12/09/2025 12:41pm 164.8 Lbs. Mechanical Lift (Full Body), +1.2lbs (+.7%) 12/11/2025 1:48pm 164.2 Lbs. Wheelchair, -.6 lbs (-.5%) 12/16/2025 9:57am 161.1 Lbs. -3.1lbs (-2%)R1's Total weight loss from admission date of 11/25/2025 to date of discharge 12/16/2025 (22 Days) -14.1 lbs. or -8%.On 01/20/26 at 10:37am, R1's medical record review documents during R1's stay at the facility R1 was served 61 meals. Of those 61 meals, six of the meals did not include documentation of the percentage of consumption. Twenty-nine of the 55 meals documented was less than 50% consumed. Fifteen of the 55 meals documented was less than 25% consumed.On 01/15/26 at 10:23am, V9 Licensed Practical Nurse (LPN), stated the note in the medical record was written by V9. V9 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated V9 could not recall notifying the family or physician of a decline in health of R1. V9 stated V9 did not inform the physician or family of R1's weight loss.On 01/15/26 at 10:56am, V12 Registered Nurse/Nurse Practitioner (NP) confirmed V12 was not informed of the weight loss R1 was experiencing. V12 confirmed limited consumption of meals would lead to weight loss and electrolyte imbalance.On 01/15/26 at 12:48pm, V14 Registered Dietician (RD) confirmed V14 was not informed of the weight loss by R1. V14 stated V14 would have asked for a re-weight of R1 to confirm the weight loss and then made recommendations based on clinical evidence of the weight loss.On 01/15/26 at 12:48pm, V15 Primary Care Physician confirmed V15 was not notified of the weight loss by R1. V15 confirmed if R1 was consuming less than 50% of meals it would lead to weight loss and electrolyte imbalance.On 01/20/26 at 10:29am, V25 R1's family member confirmed V25 was not informed of R1's weight loss or lack of food consumption.On 01/21/26 at 12:48pm, V2 Director of Nursing (DON) confirmed R1 had a significant weight loss, and that family/Physician/Registered Dietician had not been notified of the weight loss. V2 confirmed R1 was sent to the local hospital on [DATE] for altered mental status, possible stoke.On 01/20/26 at 10:44am, R8's care plan review documents R8 was admitted to the facility on [DATE] with the following diagnosis: Mechanical Fall Acute Right Proximal Tibial and Fibular Traumatic Fracture Severe Right Lower Extremity Intractable Pain Acute Right Distal Talus Avulsion Fracture, Acute Hypotension/Acute Shock versus Anemia versus Others Acute Anemia, Suspect Secondary to Fracture and or Others, Ruled Out GI bleed No Signs of Obvious Bleeding Acute Kidney Injury on Chronic Kidney Disease, A-fib with [NAME].On 01/20/26 at 10:35am, R8's medical record review documents the following weights were obtained during R8's stay at the facility: 1/03/2026 06:46 161.1 Lbs. Mechanical Lift (Full Body)12/31/2025 09:55 156.3 Lbs. Mechanical Lift (Full Body) 12/30/2025 09:00 158.8 Lbs. Mechanical Lift (Full Body) 12/29/2025 12:42 163.9 Lbs. Mechanical Lift (Full Body) 12/28/2025 12:58 166.3 Lbs. Mechanical Lift (Full Body) 12/27/2025 11:31 166.0 Lbs. Mechanical Lift (Full Body)12/26/2025 12:17 163.7 Lbs. Mechanical Lift (Full Body) 12/25/2025 13:07 161.6 Lbs. Mechanical Lift (Full Body) 12/24/2025 13:26 168.4 Lbs. Mechanical Lift (Full Body) 12/23/2025 12:00 166.2 Lbs. Mechanical Lift (Full Body) 12/22/2025 10:44 166.7 Lbs. Mechanical Lift (Full Body)12/20/2025 11:14 172.8 Lbs. Mechanical Lift (Full Body)12/19/2025 11:28 169.4 Lbs. Mechanical Lift (Full Body)12/18/2025 13:48 178.3 Lbs. Mechanical Lift (Full Body)12/17/2025 12:06 176.2 Lbs. Mechanical Lift (Full Body) 12/16/2025 09:59 178.3 Lbs. Mechanical Lift (Full Body) 12/15/2025 13:50 178.8 Lbs. Mechanical Lift (Full Body) 12/14/2025 13:58 178.2 Lbs. Mechanical Lift (Full Body) 12/13/2025 14:20 186.8 Lbs. Mechanical Lift (Full Body) 12/12/2025 13:51 184.0 Lbs. Mechanical Lift (Full Body) 12/10/2025 14:20 184.0 Lbs. Mechanical Lift (Full Body) 12/09/2025 12:41 184.9 Lbs. Mechanical Lift (Full Body) 12/08/2025 14:46 185.5 Lbs. Mechanical Lift (Full Body)12/06/2025 14:00 198.6 Lbs. Mechanical Lift (Full Body)12/05/2025 13:58 199.8 Lbs. Mechanical Lift (Full Body) 12/04/2025 12:27 201.0 Lbs. Mechanical Lift (Full Body)12/03/2025 09:31 201.0 Lbs. Mechanical Lift (Full Body) 12/02/2025 18:22 201.8 Lbs. Mechanical Lift (Full Body) 12/01/2025 13:53 200.9 Lbs. Mechanical Lift (Full Body) 11/30/2025 16:46 198.0 Lbs. Mechanical Lift (Full Body) 11/27/2025 11:21 197.2 Lbs. Mechanical Lift (Full Body) 11/26/2025 13:25 199.3 Lbs. Mechanical Lift (Full Body)11/25/2025 11:21 192.1 Lbs. Mechanical Lift (Full Body)11/23/2025 14:36 198.0 Lbs. Mechanical Lift (Full Body) 11/22/2025 09:01 197.9 Lbs. Mechanical Lift (Full Body)R8's Total weight loss from an admission date of 11/21/2025 to date of 01/03/26 (44 Days) -36.8 lbs. or -19%.On 01/15/26 at 10:56am, V12 Registered Nurse/Nurse Practitioner (NP) confirmed V12 was not informed of the weight loss R8 was experiencing.On 1/20/26 at 10:38am, V26 R8's family member confirmed V26 was not notified of R8's weight loss. V26 stated V26 noticed R8 was losing weight but had no idea it was this drastic. V26 stated he will be talking to facility staff upon arrival this (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evening.On 1/20/26 at 11:11am, V27 (R8's Physician) confirmed V27 had not been notified of any weight loss by R8.On 01/21/26 at 12:48pm, V2 Director of Nursing (DON) confirmed R8 had a significant weight loss, and that family/Physician had not been notified of the weight loss.

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F 0602 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on Interview and record review the facility failed to replace misappropriated goods in a reasonable time frame for one (R3) of three residents reviewed for misappropriation. R3 was upset and angered of having to replace (ear buds) with R3's own personal money and the facility not reporting this to the police as R3 wanted to press charges. This failure to report to the police and to replace the goods in a timely fashion resulted in psychosocial harm to R3.Findings Include:The Facilities Abuse Prevention Policy Dated 1/25 documents that the facility affirms the right of the resident to be free from misappropriation of property, deprivation of goods and services by staff or mistreatment. This policy also documents that the facility would keep the resident informed of the conclusions of the investigations. On 11/6/2026 at 9:30PM, R3 reported that R3's (ear buds) were missing from R3's room and the facility reported this to the state agency. On 11/14/2025 the final report was provided to the state agency which documents that on 11/6/2025 R3 went to put on R3's (ear buds) that R3 kept in a specific place when R3 realized they were not there. R3 utilized the (tracking) function on R3's cellular phone and the missing (ear buds) were pinged (located) at an address (about 30 miles away). R3 asked the Certified Nursing Assistant on shift what her address was which the Certified Nursing Assistant stated she lives with her mom who is also a Certified Nursing Assistant at the facility and confirmed the address where the missing (ear buds) were located. The Facility Incident Documents that the Certified Nursing Assistance was terminated, (Local Police Department) notified, and the facility was replacing the (ear buds) for R3. On 1/13/2026 at 12:27PM, R3 stated R3's (ear buds) were missing after R3's room was deep cleaned on 11/6/2025. The Certified Nurse Assistant was helping R3 put all R3's personal belongings on R3's bedside table. R3 stated he noticed them missing when R3 went to put the (ear buds) in around 9:00PM on 11/6/2025. R3 stated that R3 used the (racking) function on R3's cellular phone which came up to an address of a mother and daughter who were employed as Certified Nursing Assistants at the facility. R3 stated R3 reported the theft to V1 but did not speak to a police officer that night. R3 stated R3 still would like to press charges but was told by V1 Administrator that no charges are being pressed. R3 stated that V1 stated they would get R3 new (ear buds), but R3 had already bought (ear buds) out of R3's own money but stated R3 would like reimbursement for the money spent on replacing the ear buds. R3 also stated V1 came into R3's room on 1/13/2026 and told R3 that the check was mailed and R3 will be getting a refund for $249.54. R3 stated that it upsets and angers R3, as this is R3's home and that someone can just steal from R3 and other residents. R3 again stated he wants to press charges as it has been over two months since the incident.

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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 altercation between two (V19 and V28) employees in presence of three (R6, R9 and R10) residents and failed to report that an unqualified individual was working as a Certified Nursing Assistant. Findings include:Documents from the (Local Sherriff's Department) documents that on 01/09/2026 V29 Sheriff Deputy (SD) was operating as a uniformed patrol for the (Local Sheriff's Office). At approximately 5:00PM, V29 SD was dispatched to the facility for a threats report. Dispatch informed V29 SD that they received a call from V18 Certified Nursing Assistant (CNA) who stated that one of the CNA's V18 was working with (V28, CNA) had threatened to beat her a** (expletive) after V28's shift ends. Dispatch soon fielded a second 911 call from V28, CNA, regarding the incident. V29 SD arrived on scene and spoke with V18 CNA who stated the following, though not verbatim. V18 CNA stated that V28 CNA told V18 to meet V28 by the time clock so that V28 could beat her a** (expletive). V18 CNA said that V28 CNA saying this caused her to feel uncomfortable and unsafe. V18 stated that this started after V28 CNA approached V18 CNA near the front desk to tell V18 that one of the residents had not been taken care of since 6:00AM. V18 CNA stated that there was miscommunication which led to V28 CNA working in the south unit of the nursing home from 6:00 AM until 2:00PM. V18 said at 2:00PM V18 CNA was moved over to the east hallway where she discovered that the resident hadn't been taken care of. V18 CNA said she told V28 CNA that was V28's job since V28 was moved over there at 2:00PM until 5:00PM. V18 CNA said that V28 CNA started accusing V18 CNA of disrespecting V28 and began yelling at V18 and threatening to fight V18 after V18 got off work. V18 CNA explained that earlier in the shift, V28 CNA had gotten into a verbal altercation with a different CNA (V19). V18 CNA said that V28 CNA threatened V19 CNA after accusing V19 of not helping V28. V18 CNA said that V18 had to separate the two of them and the situation calmed down. V19 CNA said that when V19 confronted V28 for not taking care of the resident that V28 was supposed to be responsible for, V28 began yelling at V19 and accusing V19 of disrespecting V28. V19 CNA then informed me that V1 Administrator, requested that V28 CNA clock out and leave the property. V29 SD also later spoke with V1 Administrator directly on the phone and V1 stated that V1 wanted V28 CNA permanently removed for trespassing. V28 CNA then stated V28 wasn't leaving the property until V28 got paid for the work V28 did. V28 then began to make racially derogatory comments saying, I wasn't mad at first. That's that white people s*** (expletive). V28 took out V28's cell phone and began taking photographs of V19 and V19's employee badge. V28 walked by the facility's cafeteria and began insulting V19 and V18 in front of residents. V29 later called and spoke with V1 Administrator again. V1 stated that V1 looked up V28's name on the registry and discovered that V28 isn't a CNA.On 1/15/2026 at 9:35AM, V1 Administrator stated she knew about the incident, but didn't report the incident. On 1/21/2026 at 10:35AM, V19 stated that V28 was working from 6:00AM until the incident took place around 5:00PM. V1 stated that there was an altercation of yelling and screaming from V28 in front of residents in the cafeteria and also in R8's Room.On 1/21/2026 at 10:05AM, R8 stated about a week ago two Certified Nursing Assistants were yelling and having a disagreement in R8's room. R8 stated one of the Certified Nursing Assistants walked out.

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F 0692 Level of Harm - 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 accurately assess a resident for weight loss for one (R1) of three residents reviewed for nutrition. A significant weight loss was not identified, and interventions were not put in place to prevent further weight loss resulting in R1 being admitted to the hospital with a diagnosis of Hypokalemia due to malnutrition/dehydration.Findings include:The facility policy Lab, Diagnostic Test Results and Change in Resident's Condition - Clinical Protocol Dated November 2016 documents to establish guidelines for physician notifications concerning resident lab and diagnostic tests results and change(s) in resident conditions. The policy further documents 2. The person who is to communicate results to a physician will review, compile the information and be prepared to discuss the following: a. the individual's current condition and any recent changes in status, including vital signs and mental status.The facility's undated policy Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol documents 1. Monitor and document the weight and nutritional status of residents in a format which permits readily available month-to-month comparisons. 2. Assess the individual's current nutritional status and identify individuals with anorexia, recent weight loss, and significant risk for subsequently impaired nutrition. 4. The staff will notify family of significant weight gains or losses or any abrupt or persistent decline from baseline appetite or food intake.The policy further documents 1. The physician and/or designee will review possible causes of anorexia or weight loss with the nursing staff and/or dietitian before ordering interventions. a. For individuals with recent or rapid weight loss (for example, more than a pound a day), the staff and physician should consider possible fluid and electrolyte imbalance as a cause. Monitoring: I. The physician and staff will monitor the nutritional status, response to interventions, and possible complications of such interventions (for example, aspiration, diarrhea, nausea, or vomiting) of individuals with impaired nutritional status.On 01/15/26 at 11:30am, R1's care plan documented an admission date of 11/25/2025 with diagnosis of Diabetes Mellitus Due to Underlying Condition with Diabetic Neuropathy, Unspecified (E08.40), and Other Lack of Coordination (R27.8).On 01/15/26 at 11:35am, R1's medical record review documents the following weights were obtained during R1's stay at the facility: admission weight: 11/25/2025 6:17pm 175.2 pounds (lbs) Wheelchair. 11/26/2025 1:25pm 170.4 lbs Mechanical Lift (Full Body), -4.8lbs (-3%) 11/27/2025 11:20am 157.1 lbs Mechanical Lift (Full Body), -13.3lbs (-8%) 12/5/2025 11:54am 163.6 lbs Mechanical Lift (Full Body), +6.5lbs (+4%) 12/9/2025 12:41pm 164.8 lbs Mechanical Lift (Full Body), +1.2lbs (+.7%) 12/11/2025 1:48pm 164.2 lbs Wheelchair, -.6 lbs (-.5%) 12/16/2025 9:57am 161.1 Lbs -3.1lbs (-2%)Total weight loss from admission date of 11/25/2025 to date of discharge 12/16/2025 (22 Days) -14.1 lbs or -8%.On 01/20/26 at 10:37am, R1's medical record review documents during R1's stay at the facility R1 was served 61 meals. Of those 61 meals, six of them did not document a percentage of consumption. Twenty-nine of the 55 meals documented noted less than 50% of the meal consumed. Fifteen of the 55 meals documented less than 25% consumed.On 01/15/26 at 11:35am, R1's medical record review documents on 12/16/2025 a nurse practitioner called Emergency Medical Services (EMS) to take R1 to the hospital due to R1 was exhibiting signs and symptoms of a stroke.On 01/15/26 at 11:35am, R1's hospital record review documents on 12/16/2025 R1 was admitted to the local hospital with a potassium level of 2.0 (Panic level low) on a scale of 3.5-5.1 mmol/L (millimoles per liter). The hospital discharge paperwork dated 11/25/2025 documents R1 having a potassium level of 4.0 on a scale of 3.5-5.1 mmol/L.On 01/15/26 at 11:35am, R1's medical record review documents on 12/2/25 R1 had labs done while at the facility and document a potassium level of 3.5 on a scale of 3.5-5.3 mEq/L (milliequivalents per liter). Labs drawn on 12/16/25 prior to discharge from the facility document potassium 2.6 (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	on a scale 3.5-5.3 mEq/L. Demonstrating an electrolyte imbalance/ downward trend while at the facility.On 01/15/26 at 11:35am, R1's medical record review documents on 12/11/2025 V9 License Practical Nurse (LPN), documented V23 Speech Therapist informed V9 that V23 had to assist the resident with eating lunch. V23 stated R1 seems to be declining.On 01/15/26 at 10:23am, V9 LPN stated the note in the medical record was written by V9. V9 stated V9 could not recall notifying the family or physician of a decline in health of R1. V9 stated V9 did not inform the physician or family of R1's weight loss.On 01/15/26 at 10:56am, V12 Registered Nurse/Nurse Practitioner (NP) confirmed V12 was not informed of the weight loss R1 was experiencing. V12 confirmed limited consumption of meals would lead to weight loss and electrolyte imbalance.On 01/15/26 at 12:48pm, V14 Registered Dietician (RD) confirmed V14 was not informed of the weight loss by R1. V14 stated V14 would have asked for a re-weight of R1 to confirm the weight loss and then made recommendations based on clinical evidence of the weight loss. V14 confirmed V14 did not see R1 in the nursing home and made the diet recommendation from previous speech therapy notes from R1's medical records.On 01/15/26 at 12:48pm V15, Primary Care Physician, confirmed V15 was not notified of the weight loss by R1. V15 confirmed if R1 was consuming less than 50% of meals it would lead to weight loss and electrolyte imbalance. V15 stated V15 would have ordered labs and recommendations/orders based on R1 abilities and preferences.On 01/20/26 at 10:29am V25, R1 family, confirmed V25 was not informed of R1's weight loss or lack of food consumption.On 01/21/26 at 09:18am, V23 Speech Therapist confirmed V23 noted a sharp decline in R1's abilities including talking less and not feeding herself. V23 stated on 12/11/25 V23 informed V9 that R1 was experiencing a decline in overall health and was requiring more assistance to complete tasks.On 01/21/26 at 12:48pm, V2 Director of Nursing (DON) confirmed R1 had a significant weight loss, and that family/Physician/Registered Dietician had not been notified of the weight loss. V2 confirmed R1 was sent to the local hospital on [DATE] for altered mental status, possible stoke.On 01/22/2026 at 12:24pm, V24 Hospitalist/Doctor, confirmed on 12/16/25 R1 was admitted to the hospital with the admitting diagnosis of Hypokalemia (low potassium) (electrolyte imbalance) secondary to severe malnutrition/dehydration. V24 stated R1 had to have multiple intravenous potassium injections to get the potassium back to normal range. V24 stated the lack of food and drink at the facility was the cause of the Hypokalemia.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review the facility failed to have a policy to verify the identity of agency staff to ensure one (V28) of three CNA's (V18, V19) reviewed demonstrated competency in the skills and techniques necessary to care for residents. This failure resulted in a facility wide failure and effected all 39 residents in the building. Findings Include:The facility's Certified Nursing Job Description revised on 10/11/2024 documents, qualifications to perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements are to have a current certification as a Certified Nursing Assistant in accordance with the laws of the State of Illinois. On 1/9/2026 at 5:00PM, (Local County Sheriffs) were called to the facility for an altercation between two employees (V19 and V28). (Local County Sheriff's) report documented by V29 (Deputy Sheriff) states that V19 informed V29 that V28 was operating under a false name, V20, while working at the facility as a CNA. V1 then informed V29 that V28 was working for the facility under the name V20. V29 asked V1 if V28 had provided V1 with false certifications or documentation with that name. V1 explained that the contracted staffing agency profile that V28 was using was for a CNA named V20 and that was all V1 had seen. V1 then expressed concern that V28 was working as a CNA without being certified to do so. V29 then asked V28 if V28 was actually a CNA. V28 said that she is. V28 then stated that the contracted staffing agency has her certifications under the name V20. I asked V28 if the contracted staffing agency's QR code that the facility was going to scan said V20. She stated, Yeah, because she (V20) uses my account. V1 stated that V1 looked up V28's name on the registry and discovered that V28 isn't a CNA.On 1/15/2026 at 11:05AM, V1 stated there was a Certified Nurse's Assistant that was scheduled to work through their contracted staffing agency. V1 stated that V20 was scheduled to work that day. V28 arrived for the shift and provided V20's name to be able to access to the Electronic Medical Record (EMR). V1 stated V1 didn't report the incident.On 1/15/2026 at 11:24AM, received an email which documents that V28 does not have a CNA certification on the Health Care Workers Registry (HCWR) therefore V28 was not eligible to be employed as a CNA. V28 is eligible to work in a non-CNA capacity.On 1/21/2026 at 10:05AM, V20 stated that V20 didn't pick up any shifts at the facility.On 1/21/2026 at 10:35AM, V19 stated that V28 was working from 6:00AM until the incident took place around 5:00PM. Nursing Schedule dated on 1/9/2026 documents that V20 was scheduled to work 6:00am-6:00pm that day. Per the Southern Illinois Eastern University Testing Center for Certified Nursing Assistant Qualifications in the State of Illinois includes, the person is to take a registered class, with skills and competency and take a test within the State of Illinois. Facility Provided Resident Roster Documents a Census of 39 residents.

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	01/21/2026

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 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. Based on Interview and Record Review the Facility failed to ensure Registry verification for one (V28) of three staff members reviewed for certification. This failure resulted with one (V28) working as a Certified Nursing Assistant while not certified. This failure affected all 39 residents residing at the facility. Findings Include: On 1/9/2026, V28 Certified Nursing Assistant (CNA) came to the facility and began working under the name of V20 CNA who was scheduled to work a shift at the facility as a Certified Nursing Assistant. After having a verbal altercation with V19 CNA, V28 confirmed that V28's identity was not V20. On 1/15/2026 at 11:05AM, V1 Administrator stated the facility uses a contracted agency to provide certified staff for employment as needed. V1 stated that V20 was scheduled to work 1/9/26. V28 came to work on 1/9/26 in the facility and provided V20's name as V28's own identity to be able to provide care and access the Electronic Medical Record. V1 stated V1 didn't report the incident to the state agency of the false identity and working of uncertified personnel providing resident care. V1 explained that the contracted staffing agency profile that V28 was using was for a CNA named V20 and that was all V1 had seen.On 1/15/2026 at 11:24AM, received an email which documents that V28 does not have a CNA certification according to the Health Care Worker Registry (HCWR) therefore V28 is not eligible to be employed as a CNA. V28 is eligible to work in a non-CNA capacity.On 1/21/2026 at 10:05AM, V20 stated that V20 didn't pick up any shifts at the facility. On 1/21/2026 at 10:35AM, V19 stated that V28 was working from 6:00AM until the incident took place around 5:00PM. V19 stated that there was an altercation of yelling and screaming from V28 in front of residents in the cafeteria and also in a resident's room. Nursing Schedule dated on 1/9/2026 documents that V20 was to work 6:00am-6:00pm that day.Facility Provided Resident Roster Documents a Census of 39.

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	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview and Record Review the facility failed to report to the police the misappropriation of ear buds in a timely manner for one (R3) of three residents on the sample list. Findings Include: On 11/6/2025 at 9:30PM, R3 reported to staff that R3's (ear buds) were missing from R3's room and the facility reported the misappropriation of goods to the state agency. On 11/14/2025 the final report from the state agency documents that on 11/6/2025 R3 went to put in R3's (ear buds) into the ear canal that R3 kept in a specific place when R3 realized the (ear buds) were not there. R3 utilized the (tracking) function on R3's cellular phone and the (ear buds) were pinged (located) at an address in (about 30 miles away). R3 asked one of the Certified Nursing Assistant on shift what her address was. The Certified Nursing Assistant stated she lives with her mom who is also a Certified Nursing Assistant at the facility and confirmed the address where the (ear buds) were located. The Facility Incident report documents that the Certified Nursing Assistant was terminated, (Local) Police notified, and the facility was replacing the (ear buds) for R3. On 1/13/2026 at 12:27PM, R3 stated R3's (ear buds) were missing after R3's room was deep cleaned on 11/6/2025 and a Certified Nurse Assistant was helping R3 put all the personal belongings onto R3's bedside table. R3 stated he noticed the missing (ear buds) when R3 went to put the (ear buds) in the ear around 9:00PM on 11/6/2025. R3 stated that R3 used (tracking) function on R3's phone which came up to an address of a mother and daughter who were employed as Certified Nursing Assistants at the facility. R3 stated R3 reported the theft to the staff but did not speak to a police officer that night, but R3 stated R3 still would like to press charges for the theft of the (ear buds) but was told by V1 Administrator that no charges are being pressed.On 1/13/2026 at 1:05PM, V1 Administrator stated V1 called the (Local) Police Department and talked to someone there on 11/6/2025 around 9:30PM but couldn't recall who V1 talked to.On 1/14/2026 at 9:37AM, V17 (Local Sheriff) stated there is no call log, dispatch or report to the facility on [DATE] or around those dates.On 1/24/2026 at 10:00AM, V1 stated V1 left a message with The (Local) Police Department that R3 wanted to press charges for theft. The Facilities Abuse Prevention Policy dated 1/25 documents that the facility affirms the right of the resident to be free from misappropriation of property, deprivation of goods and services by staff or mistreatment. This policy also documents that the facility would keep the resident informed of the conclusions of the investigations.