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	12/12/2024

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 40385 Based on interview and record review the facility failed to document and follow up on grievances for five (R4, R14, R18, R22, R31) of five residents reviewed for grievances in the sample list of 30. Findings include: The facility's Grievance Policy dated November 2016 documents residents and their representatives may file a grievance or complaint for concerns and the written grievances must be signed by the resident or the person filing the grievance on behalf of the resident. This policy documents grievances will be investigated within five working days, the administrator may delegate the department manager to investigate the grievance, the administrator will review the findings to determine if any corrective actions need to be taken, and the investigation findings and any corrective actions will be reported to the person who filed the grievance. This policy documents written grievance documentation will include the date the grievance was received, a summary statement, investigation steps, a summary of the findings, whether the grievance was confirmed, corrective actions taken, and the date the written decision was issued. On 12/10/24 at 9:59 AM a resident council meeting was conducted. R4 stated R4 had missing clothing including pajamas, night gowns, pants and socks within the last four months. R4 stated this was reported to V16 Maintenance Director. R22 stated R22 had blankets missing for about three months, and this was reported to V1 Administrator, V16, and V7 Activity Director. R4, R18, R22, and R31 stated that V7 helps coordinate the facility's resident council meetings and they report grievances/concerns to V21 Social Services Director, but there is no follow up on the reported concerns and actions taken. The Resident Council Meeting Minutes dated 5/30/24 document concerns of missing items in laundry. These same concerns are documented in the 6/17/24, 8/19/24, 9/16/24, and 11/11/24 Resident Council Meeting Minutes. There are no documented complaints about the food noted in the Resident Council Meeting Minutes within the last six months. The Resident Council Memorandum dated 6/17/24 documents Several residents are missing items of clothing and the follow up action as laundry will do an audit. This form does not document which residents reported this concern, what items were missing, or if these items were found. There are no documented grievances of missing clothing within the last six months other than the 6/17/24 Memorandum. (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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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/10/24 at 10:28 AM V7 stated V7 has been assisting with resident council for the last six months and missing clothing and food were some of the reported concerns. V7 stated there have been complaints that the gravy is too slimy and R14 complains that there are too many processed foods. V7 confirmed missing laundry items has been an ongoing concern since May 2024, with no follow up action recorded in the minutes. V7 stated a Memorandum was completed in June 2024 for several residents who reported missing clothing and laundry was to do an audit. V7 confirmed this was the last documented memorandum regarding missing laundry items. V7 was unsure what residents voiced the concern, what items were missing, or if these items were located, as the memorandum did not document this information. V7 provided notes from the November 2024 council meeting that document R14 was missing a dark green sweater and socks, R4 was missing pajamas and gloves, R22 was missing a hooded shirt and blankets, and R31 was missing a jacket and socks. V7 stated V7 did not do a memorandum for these missing items and V7 was unsure if the missing items were found or what steps were taken, other than V1 was notified. At 11:15 AM V7 confirmed the resident council meeting minutes do not document food complaints or follow up action taken. V7 stated V7 was unsure why V7 did not document that information. On 12/10/24 at 10:50 AM V21 stated concerns that are brought up during resident council are not documented as a grievance, but V7 documents a memorandum to follow up on the concerns. V21 confirmed there are no documented grievances for missing clothing within the last six months. V21 stated V21 doesn't really follow up if items are not found since the residents sign an admission contract that includes the facility is not responsible for missing items. On 12/10/24 at 12:10 PM V1 stated items are offered to be replaced on a case by case basis since the residents sign an admission contract that states the facility will not be held responsible for lost items.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38780 Based on observation, interview and record review the facility failed to provide showers and personal cares for residents dependent on staff for hygiene. These failures affect three (R4, R8, and R22) of four residents reviewed for activities of daily living in the sample list of 30. Findings include: The facility Bath/Shower Policy (12/2017) documents: To ensure adequate hygiene needs are met. A bath/shower is scheduled for all residents in the facility at least weekly. The facility Master Shower Schedule documents: this is to ensure that each resident is getting at least one shower a week. If we have the staff they should be getting both showers a week not just one. 1. R4's Face Sheet (12/11/24) documents R4 has the following diagnoses: Need for Assistance with personal care, Unsteadiness on Feet, Essential Tremor, Difficulty in Walking, and Generalized Muscle Weakness. R4's Comprehensive Assessment (10/1/24) documents R4 is cognitively intact and requires partial/moderate staff assistance for bathing. R4's Care Plan (current) documents R4 will receive one to two showers weekly. Provide bathing, hygiene, dressing and grooming per resident's preference as able. Ask resident preferences for schedules. The facility shower schedule documents R4 is to receive showers on Mondays and Thursdays morning. R4's Shower Report sheets documents facility staff bathed R4 eight times from 10/24/24 to 12/9/24 and does not document R4 refused any showers during that time period. Further documents R4 did not receive a shower for 13 days from 11/26/24 until receiving a shower on 12/9/24. On 12/10/24 at 10:46am, R4 stated R4 is not receiving showers and prefers showering twice a week. 2. R22's Face Sheet (12/11/24) documents R22 has the following diagnoses: Muscle Wasting and Atrophy, Difficulty in Walking, Lack of Coordination, Abnormalities of Gait and Mobility, Generalized Muscle Weakness, Unsteadiness on Feet, and Repeated Falls. R22's Comprehensive Assessment (10/11/24) documents R22 is cognitively intact, has bilateral upper and lower limb impairments, and requires substantial/maximum staff assistance for bathing. R22's Care Plan (current) documents R22 will receive shower one to two times per week, Provide bathing, hygiene, dressing and grooming per resident's preference as able. Ask resident preferences for schedules. The facility shower schedule documents R22 is to receive showers on Mondays and Thursdays morning. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R22's Shower Report sheets documents facility staff bathed R22 seven times from 10/24/24 to 12/9/24 and does not document R22 refused any showers during that time period. Further documents R22 did not receive a shower for 12 days from 11/24/24 until receiving a shower on 12/5/24. On 12/09/24 at 10am, R22 stated R22 is not receiving showers twice a week. R22 stated R22 went a couple of weeks without a shower due to the facility not having enough staff (to provide showers). On 12/10/24 at 3:20pm, V6 Minimum Data Set Coordinator confirmed all shower sheets were provided for November and December 2024. 40385 3.) On 12/09/24 at 9:52 AM R8 was in R8's room and had approximately 1/4 inch long facial hair to chin and upper lip. On 12/9/24 at 3:02 PM R8's facial hair remained to upper lip and chin. On 12/10/24 at 1:23 PM R8 was in the dining room and facial hair remained to upper lip and chin. R8's Minimum Data Set (MDS) dated [DATE] documents R8 requires partial/moderate assistance for personal hygiene. R8's care plan dated 5/15/24 documents R8 has self care deficit with activities of daily living and prefers to have facial hair removed. This care plan includes to provide showers one to two times per week and ask resident preference, and assist R8 with grooming/shaving facial hair on shower days and as needed. R8's care plan does not document R8 is resistive to cares. The facility's master shower schedule documents R8's showers are scheduled on Wednesdays and Saturdays. On 12/10/24 at 1:43 PM V9 Licensed Practical Nurse stated the Certified Nursing Assistants (CNAs) are responsible for shaving residents and this should be done at least on R8's shower days which are scheduled on Wednesdays and Saturdays. On 12/10/24 at 1:50 PM V12 and V13 CNAs confirmed R8's facial hair should be removed as part of bathing on scheduled shower days. V13 confirmed R8 had facial hair to upper lip and chin. On 12/10/24 at 3:16 PM V6 MDS Coordinator provided R8's requested November and December 2024 shower documentation. There was no documentation that R8 received showers as scheduled on 11/16/24, 11/30/24, and 12/7/24. On 12/10/24 at 3:20 PM V6 confirmed all of R8's November and December 2024 shower documentation was provided. The facility's Shaving-Male or Female policy dated 3/20/23 documents Resident will be free of facial hair-male and female. If the resident is alert and oriented and requests not to be shaved, this will be noted in the care plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to perform a mechanical lift transfer safely for one (R8) of one residents reviewed for transfers in the sample list of 30. Findings include: The Stand-Up Lift policy dated 10/30/08 documents to place the resident's feet on the foot stand and if the resident requires, secure the strap to stabilize the feet prior to raising the resident to a standing position. On 12/09/24 at 3:02 PM V11 Certified Nursing Assistant transferred R8 to and from the toilet with a mechanical sit to stand lift. V11 did not utilize the leg strap on the lift. R8's Minimum Data Set, dated dated dated [DATE] documents R8 has impaired range of motion to both legs and requires partial/moderate assistance from staff for toilet transfers. R8's Care Plan dated 5/15/24 documents R8 transfers with one staff person and gait belt. This care plan documents R8's diagnoses include epilepsy and dementia. This care plan does not document R8 uses a mechanical sit to stand lift and whether or not the leg strap is required during transfers. On 12/10/24 at 12:44 PM V10 Director of Rehab stated the leg strap on the sit to stand lift should be used when transferring any resident.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to monitor urine characteristics, timely report changes in urine and urine culture results to the provider, and implement infection control measures to prevent catheter associated urinary tract infections (CAUTI) for one (R32) of two residents reviewed for UTIs in the sample list of 30. These failures resulted in delayed treatment of R32's CAUTI and hospitalization . Findings include: The facility's Notification for Change in Resident Condition or Status policy dated 12/7/17 documents to notify the resident's physician for sudden, change or unrelieved symptoms, when there is a need to alter treatment significantly and when there are symptoms of infection. This policy documents to record information related to the resident's change in condition in the resident's medical record. The facility's Enhanced Barrier Precautions (EBP) dated 7/13/23 documents EBP are used to reduce transmission of multidrug-resistant organisms and includes wearing a gown and gloves for high-contact care activities for residents with an indwelling medical device. On 12/11/24 at 11:10 AM R32 stated R32 admitted to the facility with a urinary catheter in May 2024, R32's urine had blood (hematuria) for a few weeks and R32 was hospitalized for urosepsis. R32 stated on 7/19/24 R32 felt the urge to urinate, urine leaked around R32's catheter, R32 had the nurse remove the catheter and R32 was able to urinate. R32 stated R32's catheter was blocked with mucus that had been present in R32's urine for a few days prior. R32 stated R32 went to the emergency roiagnom on [DATE] and was prescribed Levaquin for UTI and the urine culture results came back on 7/21/24, but R32's antibiotic was not changed until 7/24/24. R32 stated R32 started to feel worse on the evening of 7/24/24 and was admitted to the hospital for seven days for a UTI and treated with intravenous (IV) antibiotics. R32 stated staff emptied R32's catheter and was aware of the blood and mucus, but was unsure if any follow up was done. R32 stated R32 was concerned that R32's urinary changes weren't addressed timely, but R32 had never had a catheter before so R32 was not sure what the protocol was. R32 stated the facility did not implement EBP until November 2024. R32's Minimum Data Set (MDS) dated [DATE] documents R32 is cognitively intact. R32's MDS dated [DATE] documents R32 was dependent on staff assistance for toileting hygiene. R32's Care Plan initiated 5/11/24 and resolved 7/22/24 documents R32 had a urinary catheter for obstructive uropathy and includes an intervention to monitor/record/report signs/symptoms of UTI including pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns to the physician. R32's Nursing Note dated 5/11/2024 at 3:00 PM documents R32's urinary catheter was draining clear urine and R32's stool softener was held due to loose stools. There is no documentation of R32's urine characteristics and monitoring after this note until 5/24/24 at 9:49 AM when R32 had hematuria and blood clots in R32's urinary collection bag and R32 was sent to the emergency room . (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	R32's Hospital History & Physical dated 5/24/24 documents R32 reported having cloudy/dark urine intermittently in R32's urinary catheter. R32's workup was notable for elevated white blood cell count of 14.96, and his urinalysis appeared infected. R32 was admitted for sepsis secondary to CAUTI. R32 returned to the facility with a urinary catheter and there is no documentation that R32's urine was assessed and monitored between 7/6/24 and 7/18/24. R32's Nursing Note dated 7/19/24 at 6:59 AM documents R32 complained of lower abdominal pain and R32's urinary collection bag was empty and the catheter was not draining. R32's urine contained a large amount of sediment and mucus and had a foul odor. R32 requested to remove the catheter, upon removal R32 urinated intermittently and R32 complained of burning with urination. R32 was transported to the local emergency room per R32's request. R32's emergency room Notes dated 7/19/24 documents CAUTI, culture pending, R32's catheter was discontinued and R32 discharged back to the facility with orders for Levaquin (antibiotic) 500 milligrams (mg) by mouth daily for five days. R32's July 2024 Medication Administration Record documents Levaquin was administered 7/19-7/23/24. R32's Urine Culture with result date of 7/21/24 documents the hospital sent the results to the facility via electronic facsimile on 7/21/24 at 4:44 PM, and the organism Proteus Mirabilis was resistant to Levaquin. There is no documentation in R32's medical record that this culture was reported to a practitioner prior to 7/24/24 at 10:11AM when new orders were given for Amikacin (antibiotic) 750 mg intramuscularly (IM) every 12 hours for five days. R32's Nursing Note dated 7/24/24 at 9:43 PM documents at 8:47 PM R32 was given one dose of IM antibiotics prior to being sent to the hospital for complaints of numbness in R32's arms and hands and generally not feeling well and R32 was clammy and sweating. This note documents V18, R32's Family, was present and was concerned R32 was septic from UTI due to R32's prior history of being septic from UTIs. R32's Hospital History & Physical dated 7/24/24 at 11:36 PM documents R32 reported that despite taking Levaquin R32 developed feelings of palpitation as if R32's heart was racing and associated numbness and generalized weakness which is usually consistent with an infection. R32 was admitted for complicated UTI and treated with IV antibiotics. On 12/11/24 at 12:07 PM V6 Infection Preventionist/MDS Coordinator stated for residents with urinary catheters the nurses should monitor urine characteristics for infection and notify the provider of UTI symptoms and document this in the nursing notes. V6 confirmed R32's urine culture results were received on 7/21/24 and indicated a resistance to Levaquin, and this was not reported until 7/24/24. V6 stated it was a weekend and the floor nurses should have reported the results to the provider immediately. On 12/11/24 at 12:45 PM V6 stated EBP was implemented in October 2024, confirming R32 was not on EBP when R32 had a catheter in May and July 2024. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 12/11/24 at 1:53 PM V15 Nurse Practitioner stated staff should be routinely monitoring urine color and characteristics, including discharge and sediment, and ensure the urinary catheter is clean. V15 stated if R32 had hematuria the nurses should have notified V15 and V15 would have ordered a repeat urinalysis and assessed R32. V15 confirmed R32 was hospitalized for urosepsis in May and then a UTI in July 2024. V15 stated the nurses definitely should have been assessing R32's urine routinely and documenting this. In regards to R32's 7/21/24 urine culture, V15 stated R32's culture should have been reported as soon as the report was available, and V15 would have changed the antibiotic as soon as V15 was notified. V15 confirmed the facility should have implemented EBP for R32, which is a measure to prevent infections.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 51951 Based on observation, interview, and record review the facility failed to replace an oxygen mask weekly, failed to store respiratory equipment in a manner to prevent cross contamination, failed to follow an intervention to re-insert a tracheostomy, failed to ensure a replacement tracheostomy was kept at bedside, and failed to administer oxygen per physician's order for two (R23, R24) of four residents reviewed for respiratory care on the sample list of 30. Findings include: The facility's oxygen policy with a review date of March of 2019 documents oxygen will be administered as ordered by the physician. This policy documents tracheostomy oxygen masks will be changed once a week. 1.) R23's tracheostomy care plan dated 1/3/24 documents R23 has a tracheostomy due to a total Laryngectomy. This care plan includes interventions to monitor R23 for removal of the tracheostomy and to encourage R23 to replace the tracheostomy. This care plan also includes an intervention to keep an extra tracheostomy tube and obturator at the bedside. On 12/09/24 at 9:29 AM, R23's tracheostomy oxygen mask was lying on the bed and was dated 9/15/24. R23's suction catheter tubing was lying directly on top of R23's bedside table. R23 was sitting in a wheelchair in the room. R23's tracheostomy was lying in a container on the bedside table. When asked if R23 had a tracheostomy inserted, he pointed at his neck and there was not a tracheostomy in place. At that time, V3 Licensed Practical Nurse stated R23 removes the tracheostomy and that she would go in and replace it. On 12/09/24 at 1:00 PM, R23's tracheostomy continued to be in the container on the bedside table. At that time, V3 stated she had not reinserted the tracheostomy yet. V3 walked into R23's room and could not find a replacement tracheostomy at the bedside. On 12/09/24 at 1:02 PM, V15 Nurse Practitioner stated the staff should ensure that R23's tracheostomy is in place. On 12/09/24 at 2:15 PM, V6 Registered Nurse/Care Plan Coordinator stated R23's replacement tracheostomy was locked in her office and not at R23's bedside. On 12/09/2024 at 3:24 PM, V19 Licensed Practical Nurse for V20 Physician stated R23's tracheostomy is not used to keep an open airway but is helpful for infection control purposes. The facility's tracheostomy care policy with a revision date of 3/29/19 documents a replacement tracheostomy will be kept at the head of the bed, clearly visible. 2.) R24's care plan dated 11/4/24 documents R24 has a diagnosis of Chronic Obstructive Pulmonary Disease. This care plan includes an intervention for oxygen at two liters per nasal cannula. On 12/09/24 at 10:21 AM, R24 was receiving oxygen at five liters per nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R24's physician order dated 11/4/24 documents R24's oxygen order as two to four liters per nasal cannula. On 12/12/2024 at 2:38 PM, V6 Registered Nurse stated that R24's oxygen should be delivered at two liters per nasal cannula.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to sufficiently staff certified nursing assistants (CNAs). This failure affects four (R4, R18, R22, R31) of 16 residents reviewed for staffing in the sample list of 30. This failure has the potential to affect all 32 residents in the facility. Findings include: On 12/10/24 at 9:59 AM during the resident council meeting, R4, R18, R22, and R31 stated the facility does not have enough CNAs and they wait up to an hour for their call lights to be answered. R4 and R22 stated they have not been getting their showers which are scheduled twice per week. R4's Minimum Data Set (MDS) 10/1/24 documents R4 as cognitively intact and requires supervision/touching assistance to dependence on staff for activities of daily living (ADLs). R18's MDS dated [DATE] documents R18 as cognitively intact and requires setup/clean up to substantial/maximal assistance from staff for ADLs. R22's MDS dated [DATE] documents R22 as cognitively intact. On 12/10/24 between 3:00 PM and 4:00 PM V13 and V17 CNAs were the only CNAs working in the facility. At 4:00 PM V17 stated the facility staffs two to three CNAs for the evening shift. On 12/09/24 at 10:08 AM V12 CNA stated there are usually three to four CNAs working and on rare occasions there are two. V12 stated V12 does not feel that two CNAs is enough since there are a lot of residents who require full mechanical lifts for transfers and sometimes showers don't get done. On 12/10/24 at 12:28 PM V6 Minimum Data Set Coordinator provided a list of residents who use a full mechanical lift which is documented on the facility's Daily Census dated 12/9/24. This list documents 17 out of 34 residents use a full mechanical lift for transfers. The facility's Long-Term Care Facility Application for Medicare and Medicaid dated 12/11/24 documents the resident census as 32. The facility's Facility Assessment with reviewed date 5/23/24 documents the facility has 60 beds and resident acuity is determined by the residents' physical, cognitive, behavior and medical needs. This assessment documents the facility's staffs two to four CNAS on first and second shifts and one to two on night shift, which can be altered to more or less to meet the needs of the residents. This assessment does not identify the average census that these staffing numbers are based on. The facility's November 2024 CNA schedule documents one CNA worked night shift on 11/27/24 and 11/30/24, and two CNAs on dayshift on 11/28/24, two CNAs on night shift on 11/26/24 and 11/27/24, and one CNA from 6:00 PM -10:00 PM on 11/29/24. The facility's December 2024 CNA schedule documents two CNAs worked on days and/or evenings on 12/1/24-12/6/24, one CNA after 6:00 PM for evenings and night shift on 12/7/24, and one CNA on nights on 12/3/24 and evenings on 12/8/24. (continued on next page)

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	145948	A. Building B. Wing	12/12/2024

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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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility Master Shower Schedule documents: this is to ensure that each resident is getting at least one shower a week. If we have the staff they should be getting both showers a week not just one. On 12/10/24 at 12:10 PM V1 Administrator stated the facility's average census is in the 30's and staffing in the facility assessment is based on the census. On 12/10/24 at 3:02 PM V1 confirmed the CNA schedules for 11/23/24-12/10/24 were accurate. V1 stated there have not been any other days besides 12/9/24 that a nurse worked as a CNA. V1 stated we try to staff three CNAs on dayshift and two CNAs for evenings and night shifts. V1 stated the facility staffing is based on the direction of corporate staff and based on resident acuity and census.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 40385 Based on observation, interview, and record review the facility failed to staff a full time Director of Nursing (DON). This failure has the potential to affect all 32 residents in the facility. Findings include: On 12/09/24, 12/10/24 and 12/11/24 between 9:15 AM and 4:00 PM there was no DON observed working in the facility. The facility's Facility Assessment with reviewed date 5/23/24 documents the facility will staff a full time DON. The facility's nurse schedule dated 11/23/24-12/15/24 does not document a full time DON. On 12/10/24 at 11:35 AM V1 Administrator stated the facility has been without a full time DON since December 2023. The facility's Long-Term Care Facility Application for Medicare and Medicaid dated 12/11/24 documents the resident census as 32.

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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. 35347 Based on interview and record review, the facility failed to document registry verifications of nurse aide competency for five newly hired nurse aides prior to beginning employment in the facility. This failure has the potential to affect all 32 residents residing in the facility. Findings include: Facility employee files document the following staff hire dates: V11 on 10/17/2024, V12 on 10/21/2024, V22 on 10/4/2024, V23 on 11/6/2024, and V24 on 11/21/2024. The same records document the facility did not check the nurse aide registry for competency verification for V11, V12, V22, and V23 until 12/11/2024 and did not complete the check for V24 until 11/22/2024. On 12/12/2024 at 10:30AM, V1 (Administrator) reported the facility completed background checks for all staff prior to hire but the facility could not document the checks were done prior to staff beginning work in the facility. The facility Long-Term Care Facility Application for Medicare and Medicaid (12/11/2024) documents 32 residents reside in the facility.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 40385 Based on interview and record review the facility failed to ensure medications were available and administered as ordered resulting in significant medication errors for two (R8, R18) of 10 residents reviewed for medication administration in the sample list of 30. Findings include: The facility's Medication Administration policy dated 11/18/17 documents medications must be prepared and administered within one hour of the ordered time and record the medication administration on the Medication Administration Record (MAR) after after the medication is given. This policy documents to record on the MAR when a medication is not given and the reasoning, notify the physician as soon as practical when there is a missed dose of a scheduled medication, and if a medication is not available contact the pharmacy and then notify the physician of when the medication is expected to be available. 1.) R8's November 2024 MAR documents to administer Losartan Potassium 25 milligrams (mg) give half tablet by mouth once daily at 8:00 AM for hypertension (high blood pressure). This MAR documents R8's Losartan was not administered on 11/20/24, 11/21/24, and 11/23/24 and refers to R8's nursing notes. R8's Nursing Note dated 11/20/24 at 8:27 AM documents Losartan was reordered. R8's Nursing Notes dated 11/21/24 at 7:35 AM and 11/23/2024 at 8:52 AM documents Losartan was not available. There is no documentation that R8's physician was notified of the missed doses of Losartan or follow up communication with the pharmacy. On 12/9/24 at 2:43 PM V9 Licensed Practical Nurse confirmed there have been pharmacy medication supply issues. V9 stated the facility has a backup medication system that includes a supply of Losartan 25 mg tablets. V9 stated the nurses should notify the physician of missed doses of medications and when medications are unavailable, and this should be documented in the nursing notes. On 12/10/24 at 12:10 PM V1 Administrator confirmed a check mark on the MAR indicates the medication was given and if the MAR refers to the nursing notes there should be documented rational why the medication wasn't given. The facility's undated backup medication supply list includes four tablets of Losartan 25 mg. 2.) R18's November and December 2024 MARs document to give Insulin Glargine 13 units subcutaneously (Sub Q) at bedtime for Type 2 Diabetes Mellitus and this medication was not signed out as given on 11/12/24 and 12/1/24. These MARs documents to give Insulin Lispro 6 units Sub Q before meals and Novolog insulin per blood glucose based sliding scale before meals at 7:00 AM, 11:00 AM, and 5:00 PM. These medications were not administered on 11/12/24 at 5:00 PM and 11/13/24 at 7:00 AM and there are no recorded blood glucose results for these dates/times. These MARs document NA (not applicable) for R8's Novolog and blood glucose checks scheduled at 7:00 AM on 11/1/24, 11/5/24, 11/9/24, 11/20/24, 11/23/24, and 12/5/24, and scheduled at 11:00 AM on 12/5/24 and 12/6/24. There are no orders to hold R18's insulin. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18's Nursing Notes document the following: On 11/18/24 at 8:41 AM R18 refused to eat and Lispro 6 units was not given and at 6:05 PM R18 at less than 50% of supper so Lispro 6 units was not given. On 11/22/24 at 1:07 PM R18 ate 20-25% of the meal and Lispro 6 units was not given. On 12/5/24 at 12:26 PM R18 refused to have his blood glucose checked. On 12/6/24 at 8:56 AM Novolog was not given due to waiting on order clarification and at 11:56 AM Novolog was not available to be given. There are no other recorded nursing notes corresponding with the listed dates of insulin omission and there is no documentation that R18's physician was notified on these dates. On 12/10/24 at 12:10 PM V1 stated withholding insulin should be reported to the physician. V1 stated V1 believes an agency nurse was unable to locate R18's Novolog insulin on 12/5/24 and 12/6/24 and the nurse should have reported this to V1.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 35347 Based on observation, interview, and record review, the facility failed to employ a clinically qualified Director of Food and Nutrition Services. This failure has the potential to affect all 32 residents in the facility. Findings include: On 12/9/2024 at 9:34AM, V2 (Dietary Manager) was actively supervising dietary operations in the facility kitchen. V2 reported being the full-time manager of the facility food service and reported not being a clinically qualified Certified Dietary Manager or having equivalent training. V2 denied meeting the State of Illinois standards to be a food service manager or dietary manager. V2 denied: -being a dietician; -being a certified dietary manager; -having an associate's or higher degree in food service management or in hospitality; -having 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting; -being a graduate of a dietetic and nutrition school or program authorized by the Accreditation Council for Education in Nutrition and Dietetics, the Academy of Nutrition and Dietetics, or the American Board of Nutrition; -being a graduate, prior to July 1, 1990, of a Department (Illinois Department of Public Health) approved course that provided 90 or more hours of classroom instruction in food service supervision and having experience as a supervisor in a health care institution which included consultation from a dietician; -or having completed an Association of Nutrition & Foodservice Professionals approved Certified Dietary Manager or Certified Food Protection Professional course. On 12/10/2024 at 12:20 PM, V2 reported the facility Dietician only works in the facility one day per month and the food in the kitchen is available for all residents to eat. The Facility Assessment (5/23/2024) documents the facility will employ a dietician or other clinically qualified nutrition professional to serve as the director of food and nutrition services. Throughout the duration of the survey from 12/9/2024-12/12/2024 the facility failed to maintain sanitary food storage areas and failed to serve resident diets as planned on facility menus. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility Long-Term Care Facility Application for Medicare and Medicaid (12/11/2024) documents 32 residents reside in the facility.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 35347 Based on observation, interview, and record review, the facility failed to serve pureed diets as planned on the menu. This failure affects three residents (R2, R7, R13) of four reviewed for pureed diets in the sample list of 30. Findings include: The facility Diet Type Report (12/9/2024) documents R2, R7, and R13 all receive a pureed diet during meals in the facility. The facility Diet Spreadsheet (11/11/2024) documents residents receiving pureed diets are to receive pureed bread with their lunch meal on 12/9/2024. The facility Diet Spreadsheet (11/12/2024) documents residents receiving pureed diets are to receive pureed sugar cookie with their lunch meal on 12/10/2024. On 12/9/2024 at 11:40AM, no pureed bread was visible among the prepared food items in the kitchen being served to residents at lunch. On 12/9/2024 at 11:50AM, R7 was seated at a table in the facility dining room eating a pureed meal. No pureed bread was present with R7's meal items. On 12/9/2024 at 12:00PM, V5 (Certified Nurse Aide) was feeding R2 lunch in the facility dining room. No pureed bread was present with R2's lunch meal. V5 reported being unaware if R2 received pureed bread with R2's lunch meal. On 12/10/2024 12:14PM, R2 was eating a pureed lunch in the facility dining room. No pureed sugar cookie was present with R2's meal items. On 12/10/2024 at 12:15PM, R13 was eating a pureed lunch meal in the facility dining room. No pureed sugar cookie was present with R13's meal items. On 12/10/2024 at 12:20PM, V2 (Dietary Manager) reported residents receiving pureed diets for lunch on 12/10/2024 received pudding instead of pureed cookie because staff did not prepare pureed cookies.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35347 Based on observation, interview, and record review, the facility failed to maintain sanitary food storage areas. This failure has the potential to affect all 32 residents residing in the facility. Findings include: On 12/9/2024 at 9:341AM, the kitchen walk-in cooler flooring was soiled throughout with accumulations of dark colored decomposed food debris and spilled liquids. V2 (Dietary Manager) was present and reported not knowing the source of the liquids On 12/10/2024 at 12:20PM, the walk-in cooler remained as above. V2 was present and reported the food in the facility kitchen and cooler is available for all residents to eat. On 12/12/2024 during the noon lunch meal, the walk-in cooler remained as above. The facility Long-Term Care Facility Application for Medicare and Medicaid (12/11/2024) documents 32 residents reside in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 40385 Based on interview and record review the facility failed to implement surveillance monitoring of resident infections and implement corrective measures, and failed to develop a water management plan that included the required risk assessment, control measures, and testing protocols to reduce the risk of growth of Legionella and other pathogens in the facility's water system. These failures have the potential to affect all 32 residents in the facility. Findings include: 1.) The facility's Infection Control Surveillance and Monitoring policy dated 7/18/23 documents to implement routine surveillance and monitoring which includes observing work practices to ensure appropriate use of protective clothing/equipment, improving training to prevent recurrence, directing correct procedures to prevent infections, and enforcing hand washing by all staff after resident care. This policy documents to update the infection control logs daily and analyze the data to identify trends and the need for additional controls to prevent further spread of infection. The facility's Resident Infection Control Logs for February 2024-December 2024 document the following: In February there were two Urinary Tract Infections (UTIs) and two wound infections with Escherichia Coli (E. Coli), a bacteria commonly found in the intestines. In March there were five UTIs, and E. Coli was found in two of the UTIs and one wound infection. In April there were three UTIs, two with E. Coli. There were four UTIs in May 2024 and four UTIs, one with E. Coli In July 2024. In September 2024 there were three UTIs, one with E. Coli. There were five UTIs in October, four with E. Coli. There were six UTIs in November 2024, three with E. Coli. There were four UTIs in December, three with E. Coli. There is no documentation that the facility tracked resident infections based on resident room location. The Inservice Attendance sheets dated 3/5/24 and 3/9/24 documents staff were trained by V6 Infection Preventionist on hand washing. There is no documentation that the facility identified trends in UTIs or E. Coli and implemented any corrective action measures other than the March in-services on handwashing. On 12/11/24 at 12:07 PM the facility's infection control logs were reviewed with V6. V6 stated V6 completed the infection preventionist training course while working and was not given much training on the facility's infection control program. V6 stated E. Coli was an identified trend/pattern and training was conducted on hand hygiene, glove use, and isolation. V6 stated V6 was getting ready to do perineal care audits but that hasn't been implemented yet. V6 stated V6 just found out V6 is suppose to use the floor plan to document infections by location to identify trends, and confirmed this has not been implemented. On 12/11/24 at 2:15 PM V6 confirmed there was no other documentation of follow up education or audits completed on identified infection control trends besides the hand hygiene in-services in March. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2.) The facility's Legionella Management Procedure dated 8/10/18 documents Legionnaire's disease is a potentially fatal form of pneumonia caused by the Legionella bacteria. This bacteria is commonly found in the natural water system with no problems, but may enter man made water systems and with ideal growth conditions and susceptible population can cause an outbreak. This procedure documents the Legionella Management Team consists of the Corporate Maintenance Director, Administrator, and Maintenance Personnel, the team's duties include implementing and reviewing this procedure and the Maintenance Director is responsible for carrying out weekly/monthly checks as required and should receive training on Legionella. This procedure documents to complete a risk assessment of all water storage tanks, shower head conditions, and the configuration of pipework to prevent water stagnation and identify deadlegs. The completed risk assessment will identify and evaluate potential sources of risk and measures to prevent or control exposure to Legionella bacteria. This protocol documents the risk assessment should be reviewed at least every two years and continually updated. The Legionella Risk Assessment documents this form should be completed at least annually or upon disruption of water source and answering yes to any of the questions suggests a potential risk to being exposed to Legionella. On 12/11/24 at 1:41 PM V16 Maintenance Director was asked about the facility's Legionella plan. V16 was unsure of the facility's Legionella plan, identified risk areas and implemented control measures. V16 stated V16 was not familiar with the facility's plumbing layout and V16 had not received any training on Legionella. On 12/11/24 at 1:49 PM V1 Administrator stated corporate staff was suppose to train V16 on Legionella but this had not been done. V1 confirmed V16 was responsible for completing the Legionella Risk Assessment and implemented control measures to address the risk areas identified. On 12/11/24 at 3:30 PM V16 provided a copy of the facility's Legionella policy and procedures along with a blank risk assessment. V16 confirmed a risk assessment had not been completed and therefor no risk areas or control measures were identified. The facility's Long-Term Care Facility Application for Medicare and Medicaid dated 12/11/24 documents the resident census as 32.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 40385 Based on interview and record review the facility failed to implement its antibiotic stewardship policy by failing to evaluate clinical data to ensure infection criteria and appropriate use of antibiotics. This failure has the potential to affect all 32 residents in the facility. Findings include: The facility's Antibiotic Stewardship Program dated 11/1/17 documents the purpose of the program is to improve the use of antibiotics and to reduce antibiotic resistance by implementing core elements which includes leadership commitment, accountability, drug expertise, action, tracking, reporting, and education. This program includes a blank/incomplete checklist for the facility's Core Elements of Antibiotic Stewardship. The facility's Assessment of Infections and Antimicrobial Usage dated 11/1/17 documents to review and evaluate antimicrobial use monthly to determine whether criteria was met by determining whether the resident's documented signs and symptoms align with the recommended minimum criteria for initiating antibiotics, whether the infection met the Centers for Disease Control and Prevention's standard definitions for infection surveillance, and whether the prescribed antimicrobial aligned with the expectations as outlined in the facility's protocols. This policy includes a blank copy of McGeer Criteria for Signs and Symptoms of Urinary Tract Infections without an indwelling urinary catheter. The facility's Resident Infection Control Logs dated February - December 2024 document resident infections, antibiotics, and that clinical documentation supports antibiotic use. These logs do not document the clinical signs and symptoms for each prescribed antibiotic. These logs document in May 2024 R18 was treated with one dose of Levaquin (antibiotic) 750 milligrams by mouth for pneumonitis (lung tissue inflammation). This log does not document what R18's symptoms were. On 12/11/24 at 12:07 PM the facility's infection control logs were reviewed with V6 Infection Preventionist. V6 confirmed R18 was treated with one dose of antibiotic for a diagnoses of pneumonitis, which is not considered an infection. V6 confirmed V6 has not been using any assessment tool, such as McGeer Criteria, to determine infection criteria and appropriate antibiotic use. V6 stated V6 took the infection preventionist training course while working and was not given much training on the facility's infection control and antibiotic stewardship programs. V6 was unfamiliar with the facility's antibiotic stewardship program and did not have a copy to reference. V6 stated V1 would have the facility's antibiotic stewardship policies. The facility's Long-Term Care Facility Application for Medicare and Medicaid dated 12/11/24 documents the resident census as 32.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to offer pneumococcal vaccinations and maintain vaccination documentation for three (R18, R19, R22) of five residents reviewed for immunizations in the sample list of 30. Findings include: The Centers for Disease Control and Prevention Pneumococcal Vaccine Timing for Adults dated 3/15/23 documents for adults age 19-64, with no prior pneumococcal vaccinations, and who have chronic health conditions including Diabetes Mellitus, cigarette smoking, and chronic lung diseases, give PCV20 (Pneumococcal Conjugate Vaccine) or give PCV15 followed by PPSV23 (pneumococcal polysaccharide vaccine) at least eight weeks later. For adults over age 65 with only Prevnar13 vaccine, give PCV20 or PPSV23 a year or more after Prevnar13. For adults over age 65 with only PPSV23 vaccine, give PCV20 or PCV15 a year of more after PPSV23. The facility's Immunization of Residents policy dated 5/6/21 documents to offer the PCV13 or PPSV23 as indicated using the Pneumococcal vaccination algorithm unless contraindicated and to offer the vaccine within 30 days of admission. This policy documents to review the resident's immunization record, physician's orders, and consent forms to verify timing of prior vaccines, and record immunizations on the residents Medication Administration Record and Immunization Record. 1.) R18's ongoing Diagnosis List documents R18 age as 63 and diagnoses include Type Two Diabetes Mellitus, Interstitial Pulmonary Disease, Nicotine and Tobacco use. R18's Minimum Data Set (MDS) dated [DATE] documents R18's pneumococcal vaccination is not up to date due to R18 declining the vaccine. R18's ongoing Immunization Record does not document R18 has received or was offered a pneumococcal vaccine. There is no documentation in R18's medical record of when R18 was offered the pneumococcal vaccine. 2.) R19's ongoing diagnoses list documents R19's age as 76 and diagnoses include Asthma, Obstructive Sleep Apnea, and history of alcohol abuse. R19's ongoing Immunization Record documents R19 received Prevnar13 on 7/24/18 and there is no documentation that any additional pneumococcal vaccinations were offered or given. R19's MDS dated [DATE] incorrectly documents R19's pneumococcal vaccination as up to date. 3.) R22's ongoing Diagnoses List documents R22 age as 73 and R22's diagnoses include Atherosclerotic Heart Disease and Atrial Fibrillation. R22's ongoing Immunization Record documents R22 received Pneumovax23 on 9/1/21 and there is no documentation that any additional pneumococcal vaccinations were offered or given. R22's MDS dated [DATE] incorrectly documents R22's pneumococcal vaccination as up to date. (continued on next page)

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	12/12/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 9:40 AM V6 Infection Preventionist/MDS Coordinator stated V6 has not done anything with pneumococcal vaccinations as V6 was unsure of the vaccine schedules and when the vaccines should be offered. V6 stated R18's pneumococcal vaccination is not up to date, and per his MDS he was offered and declined. V6 stated V6 will have to locate documentation of this. V6 confirmed that based on R18's risk factors, including smoking, R18 should have been offered a pneumococcal vaccination. V6 stated R19 has not been offered the vaccine since 2018 and R22 has not been offered the vaccine since 2021. On 12/10/24 at 12:28 PM V6 stated V6 was unable to locate documentation of when R18 was offered and declined the pneumococcal vaccine.