STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145948	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to protect the residents' right to be free from verbal and physical abuse by another resident for two of four residents (R18, R23) reviewed for abuse on the sample list of 27. This failure resulted in R23 experiencing physical pain, distress, and fear after R44 hit R23 in the stomach on three separate occasions. 1. R23's Census Detail and Medical Diagnoses List dated 3/10/26 documents R23 was admitted to the facility 11/3/25 with medical diagnoses including Cerebral Vascular Accident with Physical Symptoms, Quadriplegia, Anxiety, and Contractures. R23's Minimum Data Set Assessment (MDS) dated [DATE] documents R23 is totally dependent on staff for all daily living activity including eating, oral hygiene, dressing, grooming, personal hygiene, bathing, mobility in a specialized wheelchair, and transfers between the bed and wheelchair. This MDS documents R23 is non-verbal and communicates with yes and no responses by nodding or shaking his head. This MDS documents R23 is cognitively intact with a brief interview rating of 15 out of a possible 15. R44's Census Detail and Medical Diagnoses List dated 3/10/26 documents R44 was admitted to the facility 7/22/25 with medical diagnoses including Personality Disorder, Bipolar Disorder, Schizoaffective Disorder, Major Recurrent Depression, Anxiety, Stimulant Abuse, and Cannabis Use. R44's MDS dated [DATE] documents R44 requires only supervision to accomplish all daily living activity, is ambulatory throughout the facility, uses tobacco, and makes attempts to leave the building without notifying staff. R44's Nursing Progress Note dated 1/30/26 documents, On 1/30/26 (R44) was arrested for allegations of hitting his non-verbal roommate. The roommate indicated that (R44) had hit him in the stomach on 3 occasions due to (R44) not getting his way within the facility, (Smoking/Leaving). R23's Nursing Progress Note dated 1/26/26 documents, Was reported resident had decreased appetite yesterday, fed by staff. R23's Nursing Progress Note dated 1/28/26 documents, Resident had complained of upset stomach earlier this shift and had refused breakfast. R23's Nursing Progress Note dated 1/29/26 documents, CNA (Certified Nursing Assistant, unidentified) brought resident for this writer to talk with him and to do assessment on him. Resident was afraid to return to his room r/t (related to) his roommate. After further evaluation it was found that resident made accusation that his roommate assaulted him. Resident moved to safe place in (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145948	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2026
NAME OF PROVIDER OR SUPPLIER The Haven of Bement.		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Actual harm Residents Affected - Few	facility. Resident was assessed from head to toe for any marks or bruises on him. There were no bruises or any markings from resident of an apparent assault. Resident was able to communicate with yes or no questions to answers by shaking his head yes or no. R23's Nursing Progress Note dated 1/30/26 documents, On 1/29/26 (R23) indicated his roommate hits him in the stomach. One hit each time with a closed fist and walks away. He doesn't say a word. This has happened three times in the last couple of weeks. (R23) indicated this seems to happen when his roommate is upset with something within the facility. (R23) and his roommate were immediately separated. (R23) was moved to the other hall of the facility, the cops (police) were called, the incident was investigated, and the roommate was removed from the facility in the custody of the (local) Police Department. R44 was not available for observations nor interview due to being a discharged resident. On 3/10/26 at 3:47 PM, R23 communicated with yes and no responses by movement of his head and eyes. R23 communicated he had experienced problems with his roommate (R44) who was punching him. R23 communicated it hurt and made him feel bad when R44 punched him. R23 communicated he was afraid of his roommate and the facility staff moved him (R23) to a different room. R23 confirmed R44 no longer resides in the facility. R23 was in bed watching a video device and besides his head movements, was only able to move his left arm approximately 4 inches. R23's Care Plan problem area dated 2/11/26 documents R23 is at risk of abuse: roommate was punching R23 in the stomach at night three times. R44's Involuntary Discharge Notice dated 1/30/26 documents R23 reported being in fear for his personal safety and exhibited signs of fear and distress observed by facility staff. On 3/12/26 at 9:40 AM, V1, Administrator, stated R44 had been arrested and charged with felony aggravated assault due to R23 being handicapped. The facility's Final Investigative Report to the State Agency (undated) documents R23 had complained of a stomachache on 1/29/26 and that was when R23 communicated that his roommate had struck him. This report documents that R44 was arrested by local law enforcement and R44 would not be returning to the facility. The (local) Police Department Incident Report dated 1/30/36 documents V21, Police Officer, responded to the facility, interviewed V1 Administrator, V22 Registered Nurse, V10 Social Services Director, all of whom had interviewed R23, and then interviewed R23, all with his body camera recording. V21 documented R23 confirmed the allegations of R44 punching him on three separate occasions and had fear of reprisal from R44 for reporting the assault if R44 stayed as a resident in the facility. V21 went on to document he had a previous experience with R44 in 2025 when R44 walked out of this same facility and threatened to be violent with staff if they tried to stop him from leaving. V21 documented he followed R44 for 10 blocks in his squad car, while in full uniform, and finally was able to take R44 into custody, with assistance of a deputy, as R44 walked down the middle of a state route. The county courtroom documentation dated 3/12/26 confirms R44 was arraigned on charge of aggravated felony assault. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	2. R18's Minimum Data Set (MDS) dated [DATE] documents R18 has moderate cognitive impairment. R18's current Diagnoses List documents Major Depressive Disorder, Recurrent, In Full Remission. R15's MDS dated [DATE] documents R15 is cognitively intact. R15's Current Diagnoses List documents Dementia without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety. The Initial Report dated 3/10/26, documents Yesterday (3/9/26), a (Private Company) staff member (V7,Psychotherapist/ Licensed Clinical Social Worker) brought to my (V1) attention that she heard (R15) call (R18) a name. The residents were moved to separate rooms at that time. (R18) expressed concerns to a surveyor regarding her former roommate, (R15). (R18) described feeling fearful of (R15), citing an incident where (R15) called her derogatory names the previous week, which (R18) was too afraid to report at the time. (R18) also noted that (R15) regularly uses offensive language and adopts a confrontational tone in her interactions with others. On 3/10/26 at 2:15 pm V10, Social Service Director (SSD) stated V7, Psychotherapist/ Licensed Clinical Social Worker (LCSW) came to V10 and reported that R15 and R18 had a verbal altercation yesterday (3/9/26). V10 stated I directed her to report to (V1, Administrator/Abuse Prevention Coordinator), and she did. On 3/10/26 at 3:20 pm V9, Certified Nursing Assistant (CNA) stated We all heard it. It was (R15) yelling at (R18) at first. (R18) was pretty upset, and (R15) was loud. (R18 and R15) then began to [NAME] back and forth. I went into their room and de-escalated things. As I said, (R18) was pretty upset initially and (R15) was still trying to [NAME] with her (R18). Once everything calmed down, I went and told the Administrator and one of the other CNAs told the nurse. This all happened about a week ago (prior to 3/09/26 witnessed verbal abuse allegation reported by V7 LCSW and V10, LCSW report). I reported it immediately after I calmed down the situation. On 03/10/2026 at 10:03 am R18 stated she had been R15's roommate and was moved to a separate room after R15 yelled, cussed, and used the f*** (expletive) word repeatedly. R18 stated she is afraid of R15 and did not want to give R15's name because she feels R15 would retaliate. R18 also stated this occurred about a week ago. R18 said She (R15) scares me. On 3/10/26 at 2:20 pm V1, Administrator/ Abuse Prevention Coordinator stated (V7, LCSW/Psychotherapist) was in the building doing rounds and reported that (R15) called (R18) a d*** a** (expletive). I thought of it as more of a grievance, though I did not write it on the grievance log. I recognize, it should have been handled as a potential abuse issue. The facility undated Abuse Prevention Policy documents the following: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. (continued on next page)

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	145948	A. Building B. Wing	03/13/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	This facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of property and mistreatment by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals. Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention (77 Ill. Adm. Code 300.330). Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment (42 CFR 483.12 Interpretive Guidelines). Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individual's age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never to be able to see his/her family again (42 CFR 483.12 Interpretive Guidelines).

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review the facility failed to ensure quarterly Quality Assurance meetings were held, and failed to ensure the Director of Nursing attended the Quality Assurance meetings. This failure affects all 36-residents residing in the facility.Findings include:The Quarterly Quality Assurance (QA) Committee Signature Sheet dated 3/12/2025 fourth quarter 2024 documents a QA meeting was held on that date.The Quarterly Quality Assurance Committee Signature Sheet dated 7/17/2025 first quarter 2025, (four months and 5 days after the above meeting documented as 2024 fourth quarter) documents a QA meeting was held on that date.The Quarterly Quality Assurance Committee Signature Sheet dated 12/30/25 second quarter 2025, (five months and 13 days after the above meeting documented as 7/17/25 first quarter) documents a QA meeting was held on that date. The signature sheet does not document the Director of Nursing/Infection Preventionist attended the 12/30/25 quarterly meeting.The Quarterly Quality Assurance Committee Signature Sheet dated 01/28/26 fourth quarter 2025 documents a QA meeting was held on that date. The signature sheet does not document the Director of Nursing/Infection Preventionist attended the 01/28/25 quarterly meeting.03/12/26 at 12:20 pm V1, Administrator reviewed the quarterly signature sheets and confirmed QA quarterly meetings were not conducted in a timely manner for 2025, as required and V23, Previous Director of Nursing did not attend the 12/30/25 or 1/28/26 meetings. The facility 671 form, Long Term Care Facility application for Medicare and Medicaid dated 3/12/26 documents 36 residents reside in the facility.The facility policy GENERAL QAPI (Quality Assurance and Performance Improvement) Program dated as September 2022 documents the following: GENERAL:To ensure that all services provided by the Facility to residents meet quality standards.RESPONSIBLE PARTY:The Facility implements and maintains an ongoing, Facility-wide Quality Assurance and Performance Improvement (QAA) Program designed to monitor and evaluate the quality of resident care, pursue methods to improve care quality, and resolve identified problems.POLICY:I. GoalsA. To provide a means to identify and resolve present and potential negative outcomes related to resident care and safety.B. To reinforce and build upon effective systems of services and positive care measures.C. To provide a structure and process to correct identified quality deficiencies.D. To establish and implement plans to correct deficiencies and to monitor the effects of these action plans on resident outcomes.E. To help departments, consultants, and ancillary services that provide direct or indirect care to residents to communicate effectively, and to delineate lines of authority, responsibility, and accountability; andF. To establish a system and process to maintain documentation relative to the QAPI Program, as a basis for demonstrating that there is an effective ongoing program.II. AuthorityA. The Governing Body of the Facility shall be ultimately responsible for the QAPI Program.B. The Administrator is responsible for ensuring that the Facility's QAPI Program complies with local, state, and federal regulatory requirements.C. Attendees: Administrator, DON, Medical Director (or designee), Infection Preventionist, Social Service Director, Business Office Manager, Housekeeping Director, MDS (Minimum Data Set Coordinator), Other optional attendees: Activity Director, Food Services Director, Therapy Director, Registered Dietician, Lab, Pharmacy.III. ImplementationA. The Quality Assessment & Assurance (QAA) Committee oversees implementation of the QAPI Program.i. The Quality Assessment and Assurance Chairperson, or designee, coordinates the QAA Committee activities.B. The QAA Committee will make good faith attempts to identify and correct quality deficiencies.C. The QAA committee meets at least quarterly to review reports, evaluate the significance of data, and monitor quality-related activities of all departments.D. The QAA Committee oversees and authorizes QAPI activities, including data-collection tools, monitoring tools, and the effectiveness of QAPI activities.E. The QAA Committee approves any corrective actions, including changes in policies and/or procedures, employment practices, standards of care, etc., and shall also monitor all corrective actions for effectiveness and/or the need for alternative measures.F. Individual (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	department managers will use quality indicators for programs and services in which they are involved, and which affect their function.G. The Facility will develop and implement a written QAPI Plan that will be reviewed and revised annually, or more frequently as needed.H. Information regarding QAPI activities is confidential and is disclosed only in accordance with applicable laws and regulations.I. Department managers submit their reports to the QAA Committee.IV. EvaluationA. The Facility will have effective lines of communication to obtain feedback from staff, residents, and families.B. The Facility evaluates the effectiveness of its QAPI Program at least annually and presents their conclusions to the Governing Body for review.V. CoordinatorA. The QAA Chairperson attends and/or reviews minutes of meetings of other committees or departments as needed.B. The QAA Chairperson helps other sub-committees, individuals, and departments develop quality indicators, monitoring tools, criteria, to assessment methodologies, and identify and evaluate concerns impacting resident care and safety.C. The QAA Chairperson acts as a liaison among committees, individuals, and departments regarding QAPI activities.VI. Focus - The following areas are monitored for quality and appropriateness of resident care and trends in performance and outcomes:A. Resident Rights B. Dental ServicesC. Admissions, Transfers, and Discharges D. Pharmacy Services, Medication ManagementE. Resident Behavior and Facility Practices F. Infection ControlG. Physical Environment H. Quality of LifeI. Administration J. Quality of Care, Nursing ServicesK. Nurse Aide Training L. Activity ServicesM. Disaster Preparedness N. SafetyO. Staff Development P. Dietary ServicesQ. Medical RecordsR. Rehabilitative Services S. Physician ServicesVII. Each department or service reviews its approaches to monitoring performance and outcomes and provides a summary of its findings to the QAA Committee no less than annually.VIII. Performance Improvement ProjectsA. As a part of the Facility's performance improvement activities, the Facility will conduct distinct performance improvement projects.B. The number and frequency of performance improvement projects (PIPs) will reflect the scope and complexity of the Facility's services and available resources, consistent with the Facility Assessment.C. Improvement projects must include projects that focus on high risk or problem-prone areas identified through data collection and analysis through the QAPI Program.One PIP must be completed at least annually.

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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. Based on interview and record review, the facility failed to develop and implement an antibiotic stewardship program that included protocols to ensure appropriate antibiotic use, systems to monitor antibiotic outcomes, resistance, and adverse events, and use of standardized tools and criteria to assess resident infections. This failure has the potential to affect all 36 residents in the facility.Findings include:On 3/11/2026 at 1:58AM, V2 (Regional Nurse Consultant) provided the facility antibiotic use and stewardship logs for resident infections occurring between January 2025 through March 2026. V2 reported the logs documented all of the facility antibiotic stewardship information for resident infections during the same period. On 1/8/2025 at 3:12PM, V1 (Administrator) reported the facility did not have any additional information related to their antibiotic stewardship or infection control program than the above records documented. On 3/13/2026 at 2:00pm, the above logs did not document what symptoms residents experienced signifying a potential infection, the onset of resident signs and symptoms of potential infections, the resolution of resident symptoms of infection, if any nationally recognized and standardized criteria were used to justify and guide antibiotic use, or if response to treatment was monitored to determine if the antibiotic was effective and still indicated or adjustments should be made. The logs do not document when or if an antibiotic therapy was changed when initially prescribed on an empirical basis by a medical provider or if residents experienced adverse events subsequent to antibiotic use in the facility. The facility Antibiotic Stewardship Program Guideline (4/29/2025) documents the purpose of the facility antibiotic stewardship program is to improve anti-microbial stewardship practices and to monitor outcomes and anti-microbial use. The facility Long-Term Care Facility Application for Medicare and Medicaid (3/13/2026) documents 36 residents reside in the facility.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed repeatedly to report allegations of resident-to-resident verbal abuse, to the Illinois Department of Public Health. This failure affects two of four residents (R15 and R18) reviewed for abuse on the sample list of 27.Findings include:R18's Minimum Data Set (MDS) dated [DATE] documents R18's Brief Interview of Mental Status (BIMS) score as 12 out of a possible 15, indicating moderate cognitive impairment.R15's MDS dated [DATE] documents R15's BIMS score as 15 out of a possible 15, indicating no cognitive impairment.On 03/10/2026 at 10:03 am R18 stated approximately one week ago, R15 cussed and yelled at her and she was afraid of R15. R18 then stated R18 had been R15's roommate and was moved to a separate room after R15 yelled, cussed and used the f*** (expletive) word repeatedly. R18 stated she is afraid of R15 and did not want to give R15's name because she feels R15 would retaliate. R18 said She (R15) scares me.On 3/10/26 at 10:40 am V1, Administrator/Abuse Prevention Coordinator notified by this surveyor, of the verbal abuse allegation of R18, by R15. V1 stated she was not aware of the verbal abuse allegation and will follow her abuse prevention policy and report to Illinois Department of Public Heath (IDPH) and initiate an investigation. V1 also stated R15, and resident R18 were relocated to separate rooms, partly because the previous room is being renovated and partially due to a few staff members reported the residents were not getting along. V1 stated she cannot recall who the staff were that said they were not getting along, or if not getting along had anything to do with the allegation of verbal abuse.On 3/10/26 at 2:10 pm V1, Abuse Prevention Coordinator/Administrator clarified the above interview and identified the two staff that reported the resident to resident altercation between R15 and R18 were V10, Social Service Director (SSD), and V9, Certified Nursing Assistant.On 3/10/26 at 2:15 pm V10, SSD stated that V7, Psychotherapist/ Licensed Clinical Social Worker (LCSW) came to V10, and reported that R15 and R18 had a verbal altercation yesterday (3/9/26). V10 stated I directed her (V7, LCSW) to report to (V1, Administrator/Abuse Prevention Coordinator), and she (V7, LCSW) did.On 3/10/26 at 2:20 pm V1, Administrator/ Abuse Prevention Coordinator was interviewed again regarding R15 verbal abuse of R18. V1 stated (V7, LCSW/Psychotherapist) was in the building doing rounds (3/9/26) and reported that (R15) called (R18) a d*****s (expletive). V1 stated she did not initiate an investigation, did not talk to the residents or staff, and did not report to Illinois Department of Public Health (IDPH). V1 confirmed this allegation should have been investigated and reported to determine what exactly happened. V1 stated she is sending a report to IDPH now and has started her investigation today, 3/10/26.On 3/10/26 at 3:20 pm V9, Certified Nursing Assistant (CNA) said We all heard it (V9, CNA and other unidentified Agency staff). It was (R15) yelling at (R18) at first. (R18) was pretty upset, and (R15) was loud. (R18 and R15) then began to [NAME] back and forth. I went into their room and de-escalated things. As I said, (R18) was pretty upset initially and (R15) was still trying to [NAME] with her (R18). Once everything calmed down, I went and told the Administrator and one of the other CNAs told the nurse. I can't remember who the nurse was that day. This all happened about a week ago (prior to the 3/09/26 incident reported by V7 LCSW and V10). I reported it immediately after I calmed down the situation. No one interviewed me. I reported to (V1) the administrator, that is all. The residents did not get moved to separate rooms until yesterday (3/9/26).The facility Illinois Department of Public Health (IDPH) Initial report dated 3/10/26, by V1, Administrator/Abuse Prevention Coordinator documents Yesterday (3/9/26), a (Private Company) staff member (V7, Psychotherapist/ Licensed Clinical Social Worker) brought to my attention that she (V7) heard (R15) call (R18) a name. The residents were moved to separate rooms at that time (3/9/26). (R18) expressed concerns to a surveyor regarding her former roommate, (R15). (R18) described feeling fearful of (R15), citing an incident where (R15) called her derogatory names the previous week, which (R18) was too afraid to report at the time. (R18) also noted that (R15) regularly (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	uses offensive language and adopts a confrontational tone in her interactions with others. During my interview, (R18) confirmed her fear that (R15) might yell at her again. When asked about the source of her fear, (R18) recalled an earlier conversation in which (R15, sic), (clarified as R18) threatened to inform this writer that (R15) was smoking and allowing a boy to sleep in their room-accusations that were false. (R18) is adamant that they (this) did happen. (R15) does not have access to cigarettes and no boy has slept in her room. When interviewed (R15) stated she does not smoke and the only foul language she uses is when she is joking around with the staff. (R18) and (R15) will no longer be roommates.The facility undated Abuse Prevention Policy documents the following: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents.This same policy includes:This will be done by: Filing accurate and timely investigative reports. DEFINITIONSThe following definitions are based on federal and state laws, regulations and interpretive guidelines. Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individual's age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never to be able to see his/her family again (42 CFR 483.12 Interpretive Guidelines).EXTERNAL REPORTING1. Initial Reporting of Allegations. When an allegation of abuse, exploitation, neglect, mistreatment or misappropriation of resident property has been made, the administrator, or designee, shall notify Department of Public Health's regional office immediately by telephone or fax. Public Health shall be informed that an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property has been reported to the administrator and is being investigated.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed repeatedly to investigate reported allegations of witnessed resident-to-resident verbal abuse and failed to remove the alleged perpetrator, in a timely manner. This failure affects two of four residents (R15 and R18) reviewed for abuse on the sample list of 27.Findings include:R15 and R18's Current Census records document R15 and R18 shared a bedroom from 01/01/26 until 3/09/26.R18's Minimum Data Set (MDS) dated [DATE] documents R18's Brief Interview of Mental Status (BIMS) score as 12 out of a possible 15, indicating moderate cognitive impairment.R15's MDS dated [DATE] documents R15's BIMS score as 15 out of a possible 15, indicating no cognitive impairment.On 03/10/2026 at 10:03 am R18 stated she had been R15's roommate and was moved to a separate room after R15 yelled, cussed and used the f*** (expletive) word repeatedly. R18 stated she is afraid of R15 and did not want to give R15's name because she feels R15 would retaliate. R18 said She (R15) scares me.On 3/10/26 at 10:40 am V1, Administrator/Abuse Prevention Coordinator was notified by this surveyor, of the verbal abuse allegation of R18, by R15.On 3/10/26 at 2:10 pm V1, Abuse Prevention Coordinator/Administrator confirmed the resident to resident verbal abuse allegation of R18 by R15 was reported to her previously by V10, Social Service Director (SSD) on 3/9/226 and V9, Certified Nursing Assistant.On 3/10/26 at 2:15 pm V10, SSD stated that V7, Psychotherapist/ Licensed Clinical Social Worker (LCSW) came to V10, and reported that R15 and R18 had a verbal altercation, yesterday (3/9/26). V10 stated I directed her (V7, LCSW) to report to (V1), and she (V7, LCSW) did.On 3/10/26 at 2:20 pm V1, Administrator/ Abuse Prevention Coordinator stated (V7) was in the building doing rounds and reported that (R15) called (R18) a d*** a** (expletive). I thought of it as more of a grievance, though I did not write it on the grievance log. I recognize it should have been handled as a potential abuse issue. I did not document anything in either chart. I don't see that anyone else did (document) either. V1 also stated she relocated the residents to a different room yesterday, 3/9/26 though this was reported by V9, CNA last week. V1 stated she did not initiate an investigation, did not talk to the residents or staff, and did not report to Illinois Department of Public Health (IDPH). V1 confirmed this allegation should have been investigated and reported to determine what exactly happened.On 3/10/26 at 3:20 pm V9, Certified Nursing Assistant (CNA) said she and a couple of other unidentified Agency staff all heard R15 yelling at R18 at first, and R18 was pretty upset. V9, CNA also stated she reported immediately to V1, Administrator/Abuse Prevention Coordinator last week (unidentified date), immediately after she calmed the residents down. V9 stated this all happened about a week ago (prior to 3/09/26 witnessed verbal abuse allegation reported by V7 LCSW and V10, SSD). I reported it immediately after I calmed down the situation. No one interviewed me. I reported to (V1) the administrator, that is all. The residents did not get moved to separate rooms until yesterday (3/9/26).The facility Illinois Department of Public Health (IDPH) initial report dated 3/10/26, written by V1 documents the following: Yesterday (3/9/26), a (Private Company) staff member (V7,Psychotherapist/ Licensed Clinical Social Worker) brought to my (V1) attention that she heard (R15) call (R18) a name. The residents were moved to separate rooms at that time (3/9/26). (R18) expressed concerns to a surveyor regarding her former roommate, (R15). (R18) described feeling fearful of (R15), citing an incident where (R15) called her derogatory names the previous week, which (R18) was too afraid to report at the time. (R18) also noted that (R15) regularly uses offensive language and adopts a confrontational tone in her interactions with others. During my interview, (R18) confirmed her fear that (R15) might yell at her again. When asked about the source of her fear, (R18) recalled an earlier conversation in which (R15, sic), (clarified as R18) threatened to inform this writer that (R15) was smoking and allowing a boy to sleep in their room-accusations that were false. (R18) is adamant that they (this) did happen. (R15) does not have access to cigarettes and no boy has slept in her room. When interviewed (R15) stated she does not smoke and the only foul language she uses (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	is when she is joking around with the staff. (R18) and (R15) will no longer be roommates.The facility undated Abuse Prevention Policy documents the following: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. DEFINITIONSThe following definitions are based on federal and state laws, regulations and interpretive guidelines.Abuse: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means (210 ILCS 45/1-103). Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident (42 CFR 483.5). This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain and/or maintain physical, mental, and psychosocial well-being. This assumes that all instances of abuse of residents, even those in a coma, cause physical harm or pain or mental anguish (42 CFR 483.12 Interpretive Guidelines}. The term willful in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. (42 CFR 483.5). Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention (77 Ill. Adm. Code 300.330). Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment (42 CFR 483.12 Interpretive Guidelines). Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individual's age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never to be able to see his/her family again (42 CFR 483.12 Interpretive Guidelines).The same Abuse Prevention policy documents:VI. Protection of ResidentsThe facility will take steps to prevent potential abuse while the investigation is underway. Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. In addition, the facility shall take all steps necessary to ensure the safety of residents including, but not limited to, the separation of the residents.The same Abuse Prevention policy documents:VII. Internal Investigation1. All incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected.2. Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation.The same Abuse Prevention policy documents:4. Investigation Procedures. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interview able. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked will be interviewed.

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview and record review, the facility failed to provide timely assistance for incontinence cares to four residents (R11, R12, R22, R35) of four reviewed for Activities of Daily Living in the sample list of 27 residents. Findings include:R35's Medical Diagnosis sheet (3/11/2026) documents diagnoses including Multiple Sclerosis (chronic neurological disease affecting vision, mobility, and cognition), Obstructive And Reflux Uropathy (a blockage that prevents normal urine flow), Prostatic Hyperplasia With Lower Urinary Symptoms, Muscle Wasting And Atrophy, Unsteadiness on Feet, Reduced Mobility, Abnormal Gait And Mobility, and Major Depressive Disorder. R35's Resident Assessment (1/2/2026) documents R35 is cognitively intact. The same assessment documents R35 has bilateral impairment in upper and lower extremity range of motion, is completely dependent on staff assistance for toileting hygiene, and does not have behaviors, delusions, or hallucinations.R35's Care Plan (1/5/2026) documents facility staff will check R35 frequently and assist with toileting as needed. The same record documents R35 has moisture associated skin damage to R35's coccyx and may be predisposed to skin impairment related to incontinence. On 3/10/2026 at 10:38AM, R35 reported not using an incontinent brief but using a bedpan and urinal for toileting while in bed. R35 reported activating R35's call light for staff to provide a bedpan or urinal and sometimes having to wait well over 30 minutes for staff to respond to R35's call light. R35 reported sometimes having toileting accidents while waiting for staff assistance. R35 sarcastically stated having the toileting accidents makes him feel real good. On 3/11/2026 at 11:20AM, V12 (Licensed Practical Nurse) reported V12 has received complaints from R35 about evening and night staff delays in responding to R35's call light. V12 reported R35 stated staff doesn't come quick enough responding to R35's call light. V12 reported evening and night shifts in the facility do have less direct care staff to take care of residents than during the daytime. On 3/11/2026 at 1:09PM, R11, R12, and R22 all reported having toileting accidents while waiting on facility staff to respond to call lights. The facility's call light policy (2008) documents facility staff are to answer a resident's call light as soon as possible.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed repeatedly to maintain complete and accurate medical records by failing to document incidence of resident to resident altercations. This failure affected two of four residents (R15 and R18) reviewed for abuse on the sample list of 27.Findings include:On 03/10/2026 at 10:03 am R18 stated she had been R15's roommate and was moved to a separate room after R15 yelled, cussed, and used the (f*** expletive) word, repeatedly. R18 stated she is afraid of R15 and did not want to give R15's name because she feels R15 would retaliate. R18 also stated this occurred about a week ago. R18 said She (R15) scares me.On 3/10/26 at 3:20 pm V9, Certified Nursing Assistant (CNA) stated sometime last week V9 and unidentified agency staff all heard R15 yelling at R18 and R18 was pretty upset and (R15) was loud. V9 stated R18 and R15 then began to [NAME] back and forth. V9 stated the agency staff notified the unidentified nurse and V9, CNA notified V1, Administrator/Abuse Prevention Coordinator that same day after calming residents down. There is no documentation of the allegation of verbal abuse in R15 or R18's medical records. The facility Illinois Department of Public Health (IDPH) initial report dated 3/10/26, documents reports made by V9, Certified Nursing Assistant, approximately one week ago per interview, and by V7, Psychotherapist/ Licensed Clinical Social Worker on 3/9/26. The report documents allegations of verbal abuse reported to Illinois Department of Public Health (IDPH) dated 3/10/26 and written by V1. The report documents the following: Yesterday (3/9/26), a (Private Company) staff member (V7, Psychotherapist/ Licensed Clinical Social Worker) brought to my attention that she (V7) heard (R15) call (R18) a name. The residents were moved to separate rooms at that time (3/9/26). (R18) expressed concerns to a surveyor regarding her former roommate, (R15). (R18) described feeling fearful of (R15), citing an incident where (R15) called her derogatory names the previous week, which (R18) was too afraid to report at the time. (R18) also noted that (R15) regularly uses offensive language and adopts a confrontational tone in her interactions with others. During my (V1) interview, (R18) confirmed her fear that (R15) might yell at her again. When asked about the source of her fear, (R18) recalled an earlier conversation in which (R15, sic), (clarified as R18) threatened to inform this writer that (R15) was smoking and allowing a boy to sleep in their room-accusations that were false. (R18) is adamant that they (this) did happen. (R15) does not have access to cigarettes and no boy has slept in her room. When interviewed (R15) stated she does not smoke and the only foul language she uses is when she is joking around with the staff. (R18) and (R15) will no longer be roommates.On 3/10/26 at 2:20 pm V1, stated (V7, LCSW/Psychotherapist) was in the building doing rounds and reported that (R15) called (R18) a d*** a**, (expletive). I thought of it as more of a grievance, though I did not write it on the grievance log. I recognize, it should have been handled as a potential abuse issue. I did not document anything in either chart. I don't see that anyone else did (document) either. At this time V1 reviewed R15 and R18's electronic medical record notes and confirmed V10, Social Service Director, and V7, Psychotherapist/ Licensed Clinical Social Worker nor any nurses had documented any abuse allegation or monitoring.R15's Type: Social Service Note Focus: Effective Date: 3/9/2026 at 11:54, documented by V1, Administrator/Abuse Prevention Coordinator documents this late note was created 3/12/26 at 11:56 am. This note documents Administrator and NP (unidentified Nurse Practitioner) notified resident (R15) called her (previous) roommate (R18) a name. Monitor for further behaviors. There was no documentation of alleged verbal abuse from the week before reported by V9, Certified Nurses Assistant, no documentation of the verbal abuse allegation in R15's medical record from 3/9/26 when V7, LCSW/Psychotherapist reported the allegation, and no documentation on 3/10/26 when surveyor reported the allegation of verbal abuse.R18's Type: Social Service Note Focus: Effective Date: 3/9/2026 at 11:49 am, documented by V1, Administrator/Abuse Prevention Coordinator documents this late note was created 3/12/26 at 11:53 am. This note (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documents Administrator and NP (unidentified Nurse Practitioner) notified that resident's roommate called her a name. Monitor for Anxiety and further behavior. There was no documentation of alleged verbal abuse from the week before reported to the Administrator by V9, Certified Nursing Assistant, no documentation of the verbal abuse allegation in R15's medical record from 3/9/26 when V7, LCSW/Psychotherapist reported the allegation, and no documentation on 3/10/26 when surveyor reported the allegation of verbal abuse.The undated Abuse Prevention Policy documents:VII. Internal InvestigationAll incidents will be documented whether abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected.The facility Charting and Documentation dated as revised August 2006 documents the following: Policy StatementAll services provided to the resident, or any changes in the resident's medical or mental condition, shall he documented in the resident's medical record.Policy Interpretation and Implementation1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical records.2. Entries may only be recorded in the resident's clinical record by licensed personnel (e.g., RN, LPN/LVN, QMA, physicians, therapists, etc.) in accordance with state law and facility policy. Certified Nursing Assistants may only make entries in the residents' medical chart as permitted by facility policy.3. All incidents, accidents, or changes in the resident's condition must be recorded.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interview and record review, the facility failed to have a physician document in the medical record documenting the basis of a resident's discharge, the specific needs the resident has that cannot be met in the facility, the attempts the facility made to meet those needs, and services available at the receiving facility to meet the resident's need. This failure affects one resident (R44) out of three reviewed for discharge on the sample list of twenty-seven.Findings include:R44's comprehensive, all-inclusive, Electronic Medical Record, did not include a physician note to document basis of a resident's discharge, the specific needs the resident has that cannot be met in the facility, the attempts the facility made to meet those needs, and services available at the receiving facility to meet the resident's need.R44's Involuntary Discharge Notice dated 1/30/26 documents R44 was involuntarily discharged from the facility due to being a threat to the personal safety of another resident (R23).On 3/12/26 at 9:40 AM, V1, Administrator, with V2, Director of Nursing/ Regional Consultant present, confirmed there was not a physician note in R44's medical record concerning the basis for R44's discharge. V1 confirmed R44 had been discharged from the facility and would not be returning to the facility. V1 stated she would continue looking for a physician note. As of 3/13/26 at 11:01 AM, V1 did not provide evidence of a physician note describing the required circumstances of R44's discharge. V1 stated this was her first involuntary discharge and she was not aware of all of the requirements.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to include required information regarding advocacy agencies in an involuntary discharge notice. This failure affects one resident (R44) out of three reviewed for discharge on the sample list of 27.Findings include:R44's Census Detail and Medical Diagnoses List dated 3/10/26 documents R44 was admitted to the facility 7/22/25 with medical diagnoses including Personality Disorder, Bipolar Disorder, Schizoaffective Disorder, Major Recurrent Depression, Anxiety, Stimulant Abuse, and Cannabis Use.R44's Emergency Involuntary discharge date d 1/30/26 did not include the mailing and email address of the entity which would receive a request for an appeal of the discharge, nor information on how to obtain an appeal form, complete the appeal form, and submit the appeal form. This same notice did not include the name, mailing address, email address, nor phone number of the State Long Term Care Ombudsman. This notice did not include the mailing address, email address, nor phone number of an agency responsible for the protection and advocacy of individuals with mental illness. On 3/12/26 at 9:40 AM, V1, Administrator, with V2, Director of Nursing/ Regional Consultant present, confirmed the required information was not included in R44's Involuntary Discharge Notice. V1 confirmed R44 had been discharged from the facility and would not be returning to the facility. V1 stated this was her first involuntary discharge and she was not aware of all the requirements.

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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** Based on interview and record review the facility failed to ensure a resident's bed wheels were locked for one resident (R2) out of three residents reviewed for falls in a sample of 27 residents.Findings include:The Physician Orders dated March 2026 document the following diagnoses for R2, Lumbago with Sciatica right side, Pain in the right hip, and Cellulitis of the lower right limb.The Minimum Data Set (MDS) dated [DATE] documents R2 has intact cognition, requires assistance with activities of daily living, and uses a wheelchair for mobility. The Incident Report dated 3/4/26 documents on 3/4/26 at 3:30 AM Writer (V18, LPN (Licensed Practical Nurse)) was notified by (V19, CNA (Certified Nurses Assistant)) (R2) had tried to self-transfer to go to the bathroom. (R2) was found on the floor. Full assessment was done, Vitals within normal limits, (R2) had no skid socks on. (R2) had a full mechanical lift back to bed by (V18) and (V19). The same report states under the section Notes IDT (interdisciplinary team) met to discuss. Root Cause: upon investigation, it was determined the wheels on (R2's) bed were not locked. Intervention: Staff education to ensure bed wheels are locked when resident is in bed.Attempts were made to interview V18 and V19 on 3/12/26 at 8:55 AM. On 3/12/26 at 3:30 PM V1 Administrator stated (R2) was trying to self-transfer himself to the bathroom and the wheels on his bed were not locked and the bed rolled. We don't expect the residents to be responsible for locking their bed, that responsibility belongs to staff.The facility's policy titled Fall Guidelines with revision date 8/2024 documents the following information: The intent of this guideline is the ensure this facility provides an environment that is free from hazards over which the facility has control and provides appropriate supervision to each resident as identified through the following process:Identification of hazards and risksEvaluationImplementationMonitoringAnalysis

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to wear Personal Protective Equipment (PPE) to provide care, for a resident on droplet precautions due to Methicillin-resistant Staphylococcus Aureus (MRSA) infection. This failure affects one of one resident (R3) reviewed for transmission-based precautions on the sample list of 27.Findings include:R3's Current Diagnoses list documents: Malignant Neoplasm of Unspecified Part Of The Right Bronchus Or Lung, Chronic Obstructive Pulmonary Disease, and Tracheostomy Status (surgically created airway access).R3's Private laboratory results dated [DATE], document the results of R3's sputum culture as, Moderate growth of a MRSA (multi-drug resistant, bacterial infection).R3's Current Physician Order Sheet documents the following: Isolation: Special Contact Droplet Precautions r/t (related/to) MRSA) in Trach every shift for Infection Control.R3's Care Plan dated 12/30/26 documents the following: Resident is on Contact/Droplet Isolation r/t MRSA in sputum. Resident will follow contact/droplet isolation guidance through resolution date. Dedicate the use of noncritical patient care equipment to a single patient to avoid sharing between residents. If use of common equipment is not unavoidable, then adequately clean and disinfect them before use for another resident. Educate resident and family on the need for isolation precautions. Educate family and staff regarding the transmission and treatment of infection. Isolation precautions: wear gowns, gloves and masks when providing care to resident. Place soiled linens and meal tray in bags marked biohazard. Place linens and meal tray in tightly closed bag. Wear gowns, gloves and mask when entering room. Wash hands with antimicrobial soap or hand sanitizer. Remove gown and gloves before leaving room. Remove mask when out of room. On 3/10/26 at 9:47am R3 had two large, red, hazard material barrels, just inside his bedroom door. One hazard container barrel was labeled laundry, and the other was labeled trash. R3 had two signs on his bedroom door that documented R3 is on infection control-droplet precautions and see a nurse before entering. A wall mounted rack in the hallway outside R3's room contained Personal Protective Equipment (PPE) of gloves, mask and gowns. R3 was lying in bed with his head elevated. R3 had a tracheostomy (trach) device present with an oxygen supply attached. On 3/10/26 at 9:50 m V4, Registered Nurse (RN) stated R3 is on infection control - droplet precautions for MRSA in his trach, and requires gown, mask, and gloves when staff are in his room. V4, RN stated she does not know if his MRSA is colonized and the facility has not had a re-culture of the tracheostomy site in a while. On 3/10/26 at 10:30 am R3 turned on his call light.On 3/10/26 at 10:37 am V6, Housekeeping Director entered R3's room to answer the call light. V6 did not wash her hands, use hand sanitizer, don gloves or don a gown. V6 entered R3's room with a surgical mask she had worn throughout the facility prior to entering R3's room. V6 removed R3's 24-ounce (approximate measure) sized thermal cup from his bedside table. V6 exited the room with R3's contaminated thermal cup and surgical mask. On 3/10/26 at 10:42 am V6, Housekeeping Director met with this surveyor just outside R3's room. V6 stated she was going to get a refill for R3's thermal cup. V6 confirmed she did not wear PPE in R3's room. V6, then stated I can't believe I did that. The signs are posted for droplet precautions (isolation precaution), and I am the Housekeeping Director. I know I am supposed to wear a gown and gloves when I am in his (R3's) room. I guess I am just nervous with state (Illinois Department of Public Health survey team) in the building.On 3/10/26 at 10:45 am V2, Infection Control Preventionist/Interim Director of Nursing confirmed the facility infection control protocol should have been followed. V2 said all staff are to wear PPE while in R3's room, because R3 is on isolation - droplet precautions due to MRSA in his Trach.The facility Isolation- Categories for Transmission-based Precautions Policy dated 01/20/24 documents the following: Policy Interpretation and Implementation:1. Transmission-Based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent the spread of infection.2. Signage must be placed near entry to resident room when Transmission-based Precautions are (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145948	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	necessary to indicate type of precaution and PPE needed.3. Based on CDC definitions, three types of Transmission-Based Precautions (airborne, droplet and contact) have been established. For information regarding Enhanced Barrier Precautions, please refer to the CDC Enhanced barrier precautions guideline.docx The same policy documents: b. Resident Placement(2) Isolate the individual in a private room if it is not feasible to contain drainage, excretions, blood, or body fluids (e.g., the individual is incontinent on the floor, or wanders and touches others).(4) An individual diagnosed with respiratory multi-drug resistant organisms should not be cohorted with another individual diagnosed with respiratory multi-drug resistant organism. Exceptions may apply and would require authorizations from Physicians of all residents involved.Use personal protective equipment (PPE) appropriately, including gloves and gowns. Wear a gown and gloves for all interactions that may involve contact with the resident or the resident's environment. Donning PPE upon room entry and properly discarding before exiting the resident room is done to contain pathogens.