STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146121	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benton Rehabilitation and Health Care Center	1409 North Main Street Benton, IL 62812

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of staff to resident abuse to the Illinois Department of Public Health within the required time frame for 1 (R1) of 3 residents reviewed for reporting abuse allegations in a sample of 8.The findings include: R1's admission Record documents an admission date of 2/1/2024 and included diagnoses of emphysema, hypertension, anxiety, major depressive disorder and tobacco use among others.R1's Minimum Data Set (MDS) assessment dated [DATE] documented R1 has a Brief Interview for Mental Status (BIMS) score of 9, indicating R1 has moderate cognitive impairment. This MDS also documents R1 is independent with walking and needs staff supervision for most activities of daily living.On 6/4/2026 at 8:30am, V6 (Former Social Service Director) stated when she came to work on Monday, June 1st, R1 told her about an incident that happened over the weekend between R1 and V4 (Certified Nursing Assistant/CNA). V6 stated R1 reported to her that on Saturday (5/30/2026) at 10:00am smoke break, V4 grabbed R1's right wrist, squeezed it and forcibly removed a cigarette from R1's hand. V6 said R1 had gotten a cigarette from R3 because he was done smoking and there was more of the cigarette left to smoke. V6 said R1 told her when she got the cigarette from R3, that is when V4 grabbed R1's wrist and took the cigarette away from her. V6 said she noticed V4 was at work on Monday (6/1/26) and had not been suspended pending an investigation outcome. V6 said she spoke with V1 (Administrator) about the incident and V1 told V6 the incident was not abuse, but instead was a grievance about customer service and thus did not need to be investigated or reported as abuse. V6 brought this surveyor a written statement dated 5/30/2026 (written by V3 - Licensed Practical Nurse/LPN) and stated If I don't give this statement to you directly it will disappear. It documented the following: 5/30/26, (V4/CNA) came to the desk and said (R1) took a cigarette out of another resident's hand to smoke so (V4) told me and (V5) that she (V4) grabbed (R1) by the arm and took the cigarette from (R1). (R1) told (V4) she was rough and twisted her arm back to grab the cigarette from her hand. Signed by V3.On 6/4/2026 at 8:45am, V1 (Administrator) said she did not suspend V4 when the allegation was reported to her because she did not know at the time if abuse had happened. V1 said since R1 said she didn't feel abused, V1 intended to investigate the incident as a customer service complaint and not as an abuse investigation. V1 said she did not report the allegation to IDPH because she felt it was not an abuse allegation.On 6/4/2026 at 10:10am, V3 (Licensed Practical Nurse/LPN) said she was working the day shift on 5/30/2026 with V5 (Registered Nurse/RN). V3 said around 10:00am, V4 (CNA) took the residents who smoke outside for their scheduled smoke break. V3 said afterwards, V4 came to the nurse's station and self-reported an incident between her and R1. V3 said V4 reported grabbing R1 by the wrist and forcibly removing a cigarette from her hand. V3 said R1 was very upset and acted like V4 hurt R1's arm due to twisting it backwards when removing the cigarette from R1's hand. V3 said V5 called V1 (Administrator) and reported the incident.On 6/5/2026 at 8:15am, V5 (RN) said she worked on the day shift on Saturday 5/30/2026 and was the nurse providing care for R1. V5 said V4 (CNA) came to the desk after taking the residents out for their 10:00am scheduled smoke break and self-reported to V3 and V5 an allegation of physical abuse between (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	herself (V4) and R1. V5 said V4 reported R1 claimed V4 mangled her wrist when she forcibly removed a cigarette from R1's right hand. V5 said she immediately reported the allegation to V1 (Administrator). V5 said V1 instructed her to interview R1 to see if R1 felt abused and when R1 denied feeling abused, V1 would speak to V4 on Monday about the situation, and nothing further was instructed by V1 at that time. V5 said she assessed R1's right wrist and saw no evidence of bruising or injury and R1 had normal range of motion to her right hand, wrist and arm. V5 said she didn't think V4 meant to hurt R1, but she should not have put her hands on R1 like that.On 6/5/2026 at 10:00am, V2 (Director of Nursing/DON) said per the facility's abuse policy, allegations of abuse are supposed to be reported to the Illinois Department of Public Health within two hours of receiving the allegation. The facility's Abuse, Prevention and Prohibition Policy (dated November 2025) under the section titled Reporting/Response documented the following in part: the facility administrator, employee, or agent who is made aware of allegation of abuse or neglect shall report or cause a report to be made to the mandated state agency per reporting criteria. All alleged violations involving abuse.will be reported immediately to the administrator. The person made aware of the allegations of abuse/neglect or the administrator will report the allegation of abuse and neglect to the mandated state agency. The allegation will be reported no later than 2 hours, or per stat regulation, after the allegation is made.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. The facility failed to timely initiate and thoroughly investigate an allegation of staff to resident abuse for 1 (R1) of 3 residents reviewed for abuse in a sample of 8. Findings included:On 6/4/2026 at 8:30am, V6 (Former Social Service Director) stated when she came to work on Monday, June 1st, R1 told her about an incident that happened over the weekend between R1 and V4 (Certified Nursing Assistant/CNA). V6 stated R1 reported to her that on Saturday (5/30/2026) at 10:00am smoke break, V4 grabbed R1's right wrist, squeezed it and forcibly removed a cigarette from R1's hand. V6 said R1 had gotten a cigarette from R3 because he was done smoking and there was more of the cigarette left to smoke. V6 said R1 told her when she got the cigarette from R3, that is when V4 grabbed R1's wrist and took the cigarette away from her. V6 said she noticed V4 was at work on Monday (6/1/26) and had not been suspended pending an investigation outcome. V6 said she spoke with V1 (Administrator) about the incident and V1 told V6 the incident was not abuse, but instead was a grievance about customer service and thus did not need to be investigated or reported as abuse. V6 brought this surveyor a written statement dated 5/30/2026 (written by V3 - Licensed Practical Nurse/LPN) and stated If I don't give this statement to you directly it will disappear. It documented the following: 5/30/26, (V4/CNA) came to the desk and said (R1) took a cigarette out of another resident's hand to smoke so (V4) told me and (V5) that she (V4) grabbed (R1) by the arm and took the cigarette from (R1). (R1) told (V4) she was rough and twisted her arm back to grab the cigarette from her hand. Signed by V3.On 6/4/2026 at 8:45am, V1 (Administrator) said on 5/30/2026, she received a phone call from V5 (Registered Nurse/RN) concerning an allegation of V4 (Certified Nursing Assistant/CNA) grabbing R1 by the right wrist and removing a cigarette from R1's hand when R1 would not give the cigarette to V4 when asked. V1 said she did not suspend V4 when the allegation was reported to her because she did not know at the time if abuse had happened. V1 said she did not come to the facility to investigate the allegation and decided to deal with V4 on Monday (6/1/26). V1 said since R1 said she didn't feel abused, V1 intended to investigate the incident as a customer service complaint and not as an abuse investigation. V1 said she did not report the allegation to IDPH (Illinois Department of Public Health) because she felt it was not an abuse allegation. V1 said she performed an informal investigation into the incident between R1 and V4 but did not document the investigation and cannot reproduce any evidence of performing the investigation except for a statement from R1 written on notebook paper. R1's statement documented the following: May 30th 2026, (R1) stated she is not afraid of CNA (Certified Nursing Assistant) (V4). (R1) also stated she does feel very safe around the CNA and knows that CNA did not mean to upset her or startle (R1). (R1) did say she had only wished the CNA had explained why she could not have the cigarette instead of grabbing it. At 9:30am, V1 said she began to investigate the abuse allegation self-reported by V4 on 5/30/2026.On 6/4/2026 at 9:30am, V1 (Administrator) said on Saturday 5/30/2026, V4 called her and self-reported an incident between her and R1. V1 said V4 reported R1 was stealing cigarettes again. V1 was asked if V4 reported grabbing R1 by the wrist and forcibly removing a cigarette from R1's hand and V1 answered V4 only reported grabbing R1 by the jacket sleeve and did not make contact with R1's skin. V1 again stated she did not suspend V4 pending an investigation outcome, but instead made the nurse keep V4 up at the nurse's station while V5 (Registered Nurse/RN) interviewed R1 about the incident. V1 said R1 told V5 that she was not afraid of V4, did not feel V4 abused her, but wished she would have asked her nicer and felt comfortable at this facility. V1 said R1's answers determined if V1 would investigate this incident as abuse and since R1 wasn't afraid of V4 and didn't feel abused, V1 did not investigate the incident as abuse. On 6/4/2026 at 10:10am, V3 (Licensed Practical Nurse/LPN) said she was working the dayshift on 5/30/2026 with V5 (RN). V3 said around 10:00am, V4 took the residents who smoked outside for their scheduled smoke break. V3 said afterwards, V4 came to the nurse's station and self-reported an incident between her and R1. V3 said V4 reported grabbing R1 by the wrist and forcibly removing a cigarette from her hand. V3 said R1 was very upset and acted like (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V4 hurt R1's arm due to twisting it backwards when removing the cigarette from R1's hand. V3 said V5 called V1 (Administrator) and reported the incident.On 6/5/2026 at 8:15am, V5 (RN) said she worked day shift on Saturday 5/30/2026 and was the nurse providing care for R1. V5 said V4 (CNA) came to the desk after taking the residents out for their 10:00am scheduled smoke break and self-reported to V3 (LPN) and V5 an allegation of physical abuse between herself and R1. V5 said V4 reported that R1 claimed V4 mangled her wrist when she forcibly removed a cigarette from R1's right hand. V5 said she immediately reported the allegation to V1 (Administrator).On 6/5/2026 at 10:00am, V2 (Director of Nursing/DON) said per the facility's abuse policy, allegations of abuse are supposed to be reported to the Illinois Department of Public Health within two hours of receiving the allegation. V2 said all allegations of abuse are supposed to be immediately investigated. V2 said on Monday 6/1/26, she performed her own investigation but did not document the investigation. V2 said she did type up a summarized statement. The statement documented the following: 6/1/26, On 5/29/26 [sic] it was reported by V4 that while taking the residents to their smoke break that resident (R1) had grabbed the cigarette out of the mouth of (R3) and was attempting to put in her own mouth. CNA reported that she then removed the cigarette from (R1's) hand. (R3) recently treated for respiratory illness and CNA reports she was concerned with cross contamination. Once back inside the CNA reported the incident to the nurse on duty (V5). Nurse then contacted the administrator for directions. Nurse was instructed to interview resident (R1) which she did. (R1) stated that she just wished (V4) would have asked for the cigarette instead of taking it. Nurse was asked if she felt that the situation was abuse and nurse stated that she doesn't feel like the CNA did it with any ill intention but that it could have been handled in a better way with communication. (V4) educated on effective communication and residents' rights. Understanding voiced. Signed by V2 (DON) and V4.The facility's Abuse, Prevention and Prohibition Policy dated November 2025, documented the following in part: Under the section titled Investigation, Resident abuse must be reported immediately to the Administrator. The facility Administrator will ensure a thorough investigation of alleged violations of individuals' rights and document appropriate action. While a facility investigation is under way, steps will be taken to prevent further abuse. Initiate investigation including initial reporting to all required agencies. Complete a thorough investigation. Two management level staff will conduct interviews with witnesses or other staff, residents or visitors who could have knowledge of the allegation. Witnesses will be asked to assist with completing statements. Every employee will be interviewed who was working on the specific hall/wing that the affected resident resides on. If the allegation occurred on a specific shift, all staff for the identified shift only will give a statement.