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	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benton Rehab & Hcc	1409 North Main Street Benton, IL 62812

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51735 Based on observation, interview, and record review the facility failed to assist residents during meals to promote dignity for 2 of 12 residents (R1, R15) reviewed for dining in a sample of 32. Findings include: 1. R15's Admission Record documents an admitted [DATE]. R15's Admission Record documents diagnosis in part hemiplegia and hemiparesis following cerebral infarction affecting left non-dominate side, dementia, and weakness. R15's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) was unable to be completed due to resident is rarely or never understood and has short and long-term memory problems. Section GG of that same MDS under self-care documents R15 is partial or moderate assistance with eating. R15's most recent Care Plan documents an Activities of Daily Living (ADL) deficit and intervention for eating is supervision or assist. On 4/22/2025 at 12:16 PM, V11 (Regional Consultant MDS) was feeding R15 while standing beside him as R15 was sitting at the table in the dining room. On 4/23/2025 at 3:51 PM, V11 stated she will stand or sit while feeing residents and when she assisted R15 she stood because there wasn't another chair at the table. On 4/23/2025 at 12:05 PM, V8 (Certified Nurse Aide/CNA) was feeding R15 at the same time as she was assisting another resident at the same table in the dining room. 2. R1's Admission Record documents an admitted [DATE]. R2's Admission Record documents diagnosis in part convulsions, pervasive developmental disorders, dysphagia, profound intellectual disability, and lack of coordination. R1's MDS dated [DATE] documents a BIMS of 00 indicating severe cognitive impairment. Section GG of that same MDS under self-care documents R1 is dependent with eating. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146121	A. Building B. Wing	04/24/2025

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's most recent Care Plan documents an ADL deficit and intervention for eating is total dependence. On 4/23/2025 at 12:05 PM, V8 was feeding R1 while standing beside him as R1 was sitting at the table in the dining room. V8 was also feeding R15 at the same time, at the same table in the dining room but would sit down when feeding R15. On 4/24/2025 at 10:10 AM, V8 stated she normally sits while assisting residents with meals but on 4/23/2025 she was assisting two residents at the same time, and she had to stand while feeding R1. On 4/24/2025 at 1:15 PM, V2 (Director of Nursing) stated staff should be sitting down when assisting residents with eating. The facilities undated policy titled Skills Checklist Feeding Assistance, documents residents are to be fed one at a time with staff sitting next to them at the table.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51735 Based on interview and record review the facility failed to notify the physician and the resident's responsible party of a change of condition for 1 of 2 residents (R35) reviewed for notification of changes in the sample of 32. Findings include: R35's Admission Record documents an admitted [DATE]. R35's Admission Record documents diagnosis including in part pressure ulcer of sacral region stage 4, unspecified severe protein-calorie malnutrition, type 2 diabetes, adult failure to thrive, dementia, cognitive communication deficit, and dysphagia. R35's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) of 7 which indicates severely impaired cognition. R35's most recent Care Plan documents actual/at risk and/or potential for complications with nutrition and hydration. R35's Admission Record documents V18 (Family) as R35's Power of Attorney (POA)-care substitute decision maker. R35's medical record, under weights/vitals tab documents R35 weighed 191.0 pounds on 3/4/2025, weighed via wheelchair and on 4/6/2025 R35 weighed 168.8 pounds, weighed via mechanical lift. This indicates a 22. 2 pound, 11.62% weight loss in one month. There was no documentation in R35 electronic medical record that R35's physician or that R35's POA had been notified of R35's alleged 22.2 pound weight loss in a month. On 4/23/2025 at 02:20 PM, V18 stated she has not been notified of R35 experiencing weight loss. On 4/24/2025 at 12:15 PM, V9 (Physician) stated he has not been notified of any weight loss on R35. V9 stated he would expect to be notified by the facility of any significant or severe weight loss of a resident. On 4/24/2025 at 1:32 PM, V12 (Nurse Practitioner) stated he doesn't remember being notified of R35 having any weight loss. V12 stated if a resident is experiencing weight loss he would expect to be notified. 04/23/25 9:50 AM, V3 (Dietary Manager) stated she goes through the monthly weights either the day they weigh the residents or the next day. V3 stated she saw the significant weight loss for R35, and she requested a reweigh two times and the staff told her the same weight both times. On 4/24/2025 at 1:15 PM, V2 (Director of Nursing) stated the physician and responsible party should be notified of significant/severe weight loss. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility Weight Assessment and Intervention Policy dated 12/2024 documents in part 1 month- 5% weight loss is significant; greater than 5% is severe. A Facility Significant Condition and Change and Notification Policy dated 12/2024 documents in part, Purpose: To ensure that the resident's family and/or representative and medical practitioner are notified of resident changes such as those listed below: . A significant change in the resident's physical, mental or psychosocial status . 5% weight loss or gain in 30 days .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356 Based on interview, observation, and record review, the facility failed to ensure that a resident's dresser was in a state of good repair for 1 of 1 resident (R31) reviewed for environment in the sample of 32 . Findings include: R31's Admission Record dated 04/24/25 documents an admitted [DATE] with diagnoses in part of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and other paralytic syndrome following other cerebrovascular disease affecting non-dominant side. R31's MDS (Minimum Data Set) dated 03/28/25 documents in Section C a BIMS (Brief Interview for Mental Status) score of 12 which indicates moderately impaired. R31's current Care Plan documents a focus area Restorative/Functional Program bed mobility, dressing and grooming. On 04/21/25 at 9:38AM, R31 was lying in his bed in his room. His room was noted to have one dresser in the room. The dresser was noted to have the bottom drawer hanging out and not on track and the middle drawer of dresser appeared to not have a front part to the drawer. At that time R31 who was alert and oriented stated that his dresser in his room has been like that for a while. R31 said that he has been missing the middle drawer for a while and the bottom drawer keeps falling out. On 04/23/25 at 10:20AM, R31's bottom drawer to his dresser was on track and back inside the dresser. The middle drawer was still missing the front part of the dresser. On 04/23/25 at 10:40AM, R31 stated that he doesn't use his dresser often. R31 said that he does keep some stuff in the top drawer of his dresser. On 04/24/25 at 11:35AM reviewed Facility Maintenance tracking log for April, March, February and January document nothing regarding R31's dresser drawers. On 04/24/25 at 11:45AM, V7 (Maintenance Director) stated that he was not aware that R31's dresser was broken and that the drawer in the middle is missing the front. V7 stated that when staff notices that something is broken in a resident room that they should put it on a Maintenance repair form. V7 stated that he did not get anything on R31's dresser being broken or in need of repair. V7 stated that he was going to go down right away and look at R31's dresser. V7 stated he does not do routine room checks to check for things that needs repaired. V7 stated he doesn't have a lot of time and depends on the floor staff to let him know what needs repaired. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Policy titled Facility Maintenance and Prevention Service Policy undated documents under Policy, It is the policy of the facility that maintenance follow preventative maintenance procedures for routine service and ensure proper working condition of mechanical equipment within the facility, ensure building is maintained for safety of staff and residents, routine upkeep of facility rooms, hallways and shower rooms, and ensure life safety checks are completed as required. Maintenance supervisor should complete repairs and projects in a timely manner and give routine updates on repairs ongoing in the facility to ensure status of repairs are reported and completed.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356 Based on record review, observation and interview, the facility failed to ensure a resident's AIMS (Abnormal Involuntary Movement Scale) Assessment was accurately completed for 1 of 1 resident (R20) reviewed for accuracy of assessments in the sample of 32. Findings include: R20's Admission Record dated 04/24/25 documents an admitted [DATE] with diagnoses of dementia mild with mood disturbance, anxiety, paranoid schizophrenia, agoraphobia with panic disorder, delusional disorder, and sleep disorder. R20's MDS (Minimum Data Set) dated 03/31/25 documents in Section C a BIMS (Brief Interview for Mental Status) score 13 which indicates that R20 is cognitively intact. Section GG documents eating as set-up and clean up assistance and personal hygiene as partial/moderate assistance. R20's current Care Plan documents a focus area of the resident (R20) uses antipsychotic medications r/t (related to) schizophrenia This focus area has a goal of the resident will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date. Interventions include 1. Administer psychotropic medication as order by physician monitor for side effects and effectiveness. 2. Consult with Pharmacy, MD (medical doctor) to consider dosage reduction when clinically appropriate at least quarterly. 3. Monitor/document/report PRN (As need) any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, EPS (Extrapyramidal Syndrome) (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person. R20's AIMS assessment dated [DATE] documents under instructions, either before or after completing the examination procedure, observe the resident unobtrusively at rest (e.g., in the dining room). The chair to be used in this examination should be a hard, firm one without arms. Complete the examination procedure below, before scoring the resident movement. Ask patient whether there is anything in his/her mouth (ie, gum, candy, etc) and if there is, to remove it. Examination Procedure 2. Ask resident whether he/she notices any movement in mouth, face, hands, or feet. If yes, ask to describe and to what extent they currently bother resident or interfere with his/her activities. Under Extremity Movement #5 Upper (arms, wrists, hands, fingers) include movement that are Choreic (sic) (rapid, objectively purposeless, irregular, spontaneous) or athetoid (slow, irregular, complex, serpentine). Do not include tremor (repetitive, regular, rhythmic movements) this documents none. R20's Physicians order summary documents on 03/13/25 Risperidone 2mg (milligrams) give 2mg by mouth two times a day. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/25 at 10:15AM, R20 stated that he has had abnormal movement to his right arm for a while now. R20 said that the movement is irregular and that it bothers him a lot when he is eating. R20 said that it makes it hard for him to eat because his arm is shaking and jerking when he is trying to feed himself. R20 is unsure why his right arm is doing this. On 4/24/25 at 10:15AM observed R20 lying in bed. R20's right hand and arm shaking while he was talking. R20 was trying to stop his right hand and arm from shaking by holding it with his left arm during the conversation. On 04/24/25 at 9:35AM, V5 (Registered Nurse/RN) stated that she did do the AIMS assessment for R20 on 03/13/25. V5 stated R20 does have involuntary movement to his right arm. V5 stated she was probably in a hurry and did not check the correct box on the AIMS assessment for involuntary movement of arms and hands. V5 said that she did put none, and she should have put minimal to moderate. On 04/24/25 at 10:40AM, V2 (Director of Nursing/DON) stated that R20 does have involuntary movement to his right arm. V2 stated that R20's AIMS assessment was completed incorrectly if it is marked none. V2 stated that R20 has involuntary movement to his right arm that is moderate. V2 said that she would expect the AIMS assessments completed accurately. On 04/24/25 at 11:41AM, V1 (Administrator) stated that the facility does not have a policy on AIMS assessments.

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	146121	A. Building B. Wing	04/24/2025

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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** 51792 Based on observation, interview, and record review the facility failed to provide supervision to a resident experiencing seizures and implement effective interventions to prevent falls for 1 of 1 resident (R33) reviewed for falls in the sample of 32. Findings include: R33's face sheet records an admitted [DATE]. Related diagnosis recorded in electronic medical record (EMR) include but are not limited too chronic obstructive pulmonary disorder, other seizures, migraine, unspecified, not intractable, without status migrainosus, otitis media, unspecified left ear, other amnesia, personal history of transient ischemic attack, and cerebral infarction without residual effects. R33's current Physician's Orders document R33 has an order dated 3/3/25 for Keppra 750mg (milligram) tablet - take 1 tablet twice daily; Order for lacosamide 200mg table take 1 tablet twice daily for epilepsy was ordered 12/9/24. R33's Minimum data sheets (MDS) dated [DATE] records a brief interview for mental status (BIMS) score of 15 indicating R33 is alert, oriented, and able to answer questions appropriately. Section GG of MDS - Functional Abilities - records that R33 is supervision or touching assistance for walking 10 feet, walking 50 feet with two turns, and walking 150 feet. Section I of MDS - Active diagnosis - records a diagnosis of seizure disorder or epilepsy. Section N of MDS - Medications - records resident being prescribed an anticonvulsant. Care plan dated 3/21/25 states that R33 is at risk for potential complications with falls. Interventions listed for that problem is 2/14/2025 smoking policy to be gone over and explained with resident and for her to sign the policy that's in place; 1/21/2025 medication review to be completed; 11/19/2024 resident sent to the emergency room for evaluation, labs and CT (computed tomography) were done in ER (emergency room), med review to be completed; 12/21/2024 encourage resident to sit down in dining room chair or lay down for fifteen minutes after smoking; resident to wear non-skid shoes; encourage resident to not wear crocs; nurse practitioner med review completed; 12/8/2024 Sent to ER, safety checks upon return from emergency room for forty-eight hours after return; diagnosis of ear infection with antibiotics in place; Obtain Keppra levels as ordered. 2/26/2025 re-educated staff that resident needs to sit down in dining room and/or lay down after smoking; 4/18/2025 obtain labs to check levels due to diagnosis of seizures; bed in lowest position while in bed, call light positioned for easy access while in room, check for unmet needs, encourage/assist with non-skid shoes/socks, ensure environment is free of clutter, fall review per facility protocol, have commonly used articles within easy reach. Care plan focus for ADLs (activities of daily living) record R33 as independent with ambulation, independent with toilet use, independent with transfers. On 04/21/25 at 02:22 PM, R33 stated I fell twice on Saturday. I had two seizures. I've had seizures for about 10 yrs. The doctors don't know the cause of the seizures. R33 said that if she falls that it's usually related to a seizure. (continued on next page)

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	146121	A. Building B. Wing	04/24/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/23/25 at 01:20 PM, R33 stated that her seizures began about 2014. The cause was never discovered. R33 stated she was unsure of what her current anti-seizure medications are. R33 stated she was unable to give an estimate how often she had seizures. She stated she doesn't know that she's had a seizure until someone tells her. R33 stated she remembers nothing about the event prior to or immediately after the seizure. R33 said she is unable to correlate her seizures to any activity or time. R33 stated that there is no warning of seizures. She said that the only interventions that the facility has put into place that she is aware of is to walk slow, to use the handrails, and to sit down if she feels strange in relation to falls caused by seizures. R33's EMR (electronic medical record) documents that R33 has had 7 falls while living in the facility. R33's Fall investigation dated for 2/17/25 documents that R33 had fallen on 2/14/25 due to smoking 2 cigarettes instead of her normal one cigarette. R33 walked into facility from smoking and fell to the floor. Intervention put in place was to have staff to go over the smoking policy with R33 again and have her sign it. R33's Nurse's progress note dated 2/26/25 documents that CNA (Certified Nurse Aide) observed R33 fall backwards and was unconscious. R33's Fall investigation dated 2/28/25 documents that cause of fall was determined to be falling after returning from smoking. Intervention was to re-educate staff that R33 needs to sit down or lie down immediately after returning from smoking. R33's Nurse's note dated 4/18/2025 at 5:00 PM documents, CNA witnessed resident walk out of her room stop and look up at ceiling and fall backwards. Resident didn't know what happened. No injuries noted. No bump on head. Neuro checks started. Denies pain. Assisted up without difficulty and taken back to her room. R33's Fall investigation dated for 4/22/25 documents that on 4/18/25 R33 looked up and then fell backwards. Intervention was to contact practitioner to order labs and verify anti-seizure medication levels were in therapeutic range. Nurses note dated 4/22/25 documents the following: 4/22/2025 10:12 NURSE PROGRESS NOTE Note Text: Call to (V12) regarding current falls, seizure like activity with new order: TSH (thyroid stimulating hormone, Free T4 (free thyroxine), D12 (vitamin B12 level), Keppra, Valporic, CBC (complete blood count), CMP (comprehensive metabolic panel), and folate next lab date. On 04/23/25 at 1:17 PM, R33 was noted coming into the facility from being outside smoking. There was no staff assisting her or encouraging her to sit or lie down. On 04/23/25 at 1:35 PM, V14 (Certified Nurse's Aide /CNA) stated that she is aware that R33 has seizure disorder but has never witnessed one. V14 stated the interventions she's aware of for R33 is to Make sure she's safe, check vitals, and watch where she's at. When asked if there were any interventions she was aware of to help reduce risk of injury prior to falls in general or those falls related to seizures. She said she wasn't aware of any. On 04/23/25 at 1:42 PM, V15 (CNA) stated that she is aware of R33 has a seizure diagnosis but has never witnessed one. V15 stated she didn't know anything about them. V15 stated that the only interventions she is aware of is to keep her room free of clutter and to monitor her. She said that she isn't aware of any interventions in place to prevent injury prior to falls in general or falls related to seizures. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/23/25 at 1:47 PM, V8 (CNA) stated that she is aware that R33 has a seizure disorder but has never witnessed one. She reports that the only interventions for falls or seizure activity for R33 is to keep her head protected, and afterwards they are supposed to check on her. V8 stated that she is not aware of any interventions in place to prevent injuries prior to falls in general or those related to seizures. On 04/23/25 at 1:51 PM, V5 (Registered Nurse/ RN) stated the only thing she knows about R33 that she has seizures, and they give her medicine for them. She reports that R33, Has them on occasion. V5 stated that it had been a long time since she witnessed a seizure. V5 said that she is not aware of any interventions in place to prevent injury prior to falls in general or falls related to seizures. On 4/24/25 at 9:09 AM, V2 (Director of Nurses) gave the following responses in relation to interventions reviewed with her after each of R33's falls. V2 stated that she thought that the fall intervention for the fall on 2/14/25 was appropriate because having R33 review the smoking policy and having her sign it would help to remind her of current policy and calm her down. V2 stated that R33 was upset at the time, and staff were concerned her agitation could cause a seizure and in turn, a fall. Related to fall interventions put in place for fall on 2/14/25, V2 said that she thought that the review of the policy and having her sign it, because of her agitation over not being able to smoke as often or as much due to extreme temperatures, would help to remind her and calm her down because staff were concerned that with increased agitation that it could cause a seizure and in turn a fall. Related to interventions put in place for fall on 2/26/25, V2 said that re-education of staff on having resident lay down or sit down was an appropriate intervention because R33 literally inhales two cigarettes as quickly as possible, and they thought that her blood pressure was bottoming out after she stood up. V2 said that having her sit down or lie down would help to bring her back to her normal baseline blood pressure and keep her from having a seizure or passing out. Related to 4/18/25's interventions put in place for fall, V2 said they thought that was an appropriate intervention because the facility wanted to draw levels to see if her therapeutic levels were too low, and if they could contact (MD) medical doctor and have Keppra increased which would decrease risk of seizure. V2 said that R33 is independent in all her activities of daily living (ADLs), so the only other intervention that she could think of would be to have R33 one on one with a staff member, and that is very difficult to have one to one staff/resident care.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51735 Based on observation, interview, and record review the facility failed to date and secure oxygen tubing and a humidification bottle for one of one resident (R4) reviewed for oxygen in the sample of 32. Finding include R4's Admission Record documents an admitted [DATE]. R4's Admission Record documents diagnosis including in part chronic combined systolic and diastolic heart failure, chronic obstructive pulmonary disease (COPD), and panlobular emphysema. R4's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status of 15 which indicates intact cognition. Section O of that same MDS documents R4 is on oxygen therapy. R4's most recent Care Plan documents a diagnosis of COPD with an intervention of encourage/assist R4 with oxygen as orders/accepted/needed. R4's Physician Orders for April 2025 document oxygen at 2L (liters) via NC (nasal cannula) or 5L via oxygen mask and check oxygen saturation every shift, every day and night shift. There are no physician orders as to when or how often to change oxygen tubing. On 4/21/2025 at 2:39 PM, R4 was propelling himself down the hallway in his wheelchair and his oxygen tubing was dragging on the floor behind him. On 4/22/2025 at 10:30 AM, R4 was sitting in his wheelchair in room receiving oxygen via nasal cannula and the tubing was dated 4/7/2025. The humidifier bottle on the concentrator was undated. On 4/23/2025 at 10:41 AM, R4 was laying in bed receiving oxygen via nasal cannula and the tubing was dated 4/7/2025 and the humidifier bottle on the concentrator was undated. On 4/23/2025 at 10:44 AM, V2 (Director of Nursing/DON) stated oxygen tubing is to be changed every Sunday and it is documented in the Medication Administration Record (MAR). V2 stated if it is being changed it will be in the MAR. V2 stated all oxygen tubing and the humification bottle should be dated when changed. On 04/24/25 at 1:24PM V2 (DON) stated that she would prefer that the oxygen tubing change be on the MAR to be signed off completed because she could assess it faster, but it usually always goes on the TAR (Treatment Administration Record). R4's TAR for the month of April documents oxygen at 2L via NC or 5L via oxygen mask and check oxygen saturation every shift, every day and night shift. R4's TAR does not contain any documentation as to when or how often to change oxygen tubing, nor does it document R4's oxygen tubing has been changed.

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	146121	A. Building B. Wing	04/24/2025

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51792 Based on observation, interview and record review, the facility failed to offer and provide dental services for one of one resident (R28) reviewed for dental services in the sample of 32. Findings include: R28's electronic medical record (EMR) shows an admitted [DATE]. In R28's EMR diagnoses includes but is not limited to dysarthria following cerebral infarction, anxiety disorder, other chronic pain, major depressive disorder, and alcohol abuse. R28 diagnoses did not contain any diagnosis related to dental/teeth issues. R28's MDS (Minimum Data Set) dated 3/19/25, section J documents no complaints of pain from R28. Section C of R28's MDS dated [DATE] indicates R28 had a (BIMS) brief interview for mental status score of 11, indicating moderate impaired cognition. R28's current care plan has no documentation of interventions for dental pain or a focus area of dental/teeth issues. R28's Physician's orders include a prescription for Oragel 20-0.26% 1 application dental every 6 hours as needed for oral pain with an original order date of 6/13/24. A review of R28's Medication Administration Records (MAR's) document that this medication was never administered since original order. On 04/21/25 at 1:43 PM, R28 who was alert to person, place and time stated that he has had a toothache for some time. R28 could not give this surveyor an approximation of how long his tooth had been aching. R28 stated that he takes Tylenol routinely for the pain. R28 stated that he has some teeth that are bad and need to be pulled. It is also noted that upon speaking with R28 that he has a communication deficit (stuttering and loss of words) that he said was caused by his history of a stroke. On 04/22/25 at 2:55 PM, R28 stated that he's had the toothache periodically for over the past year. When R28 was asked to show where his pain was R28 pointed to his right and left lower teeth and right upper teeth. R28 then stated that the pain is present on average 3 days a week. R28 said that he often asks the nursing staff for Tylenol, and they give it to him. He said that in the past the staff has told him that he couldn't see dental because his insurance didn't cover that. He could not remember who told him that regarding seeing the dentist due to his insurance. On 04/22/25 at 10:26 AM, R28's EHR (Electronic Health Record) was reviewed and under the miscellaneous tab was an (name of dental facility) note/referral dated 4/19/24 recommends evaluation and extraction for #32, #17, and #19. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/22/25 at 11:00 AM, R28's pain scale monitoring under vitals tab dated 12/09/24 through 4/24/25 reports that R28 has denied any pain every day except for 2/4/2025 at 20:37 (8:37pm) reports pain level of 5; and 2/8/2025 at 19:50 (7:50pm) reports pain level of 2; 2/28/2025 at 07:52 (am) pain level of 2; and 2/28/2025 at 07:53 (am) pain level of 2. R28's MAR documents R28 has a current order for acetaminophen 325mg tablets - take 2 tablets by mouth every four hours for pain. Also has current order for ibuprofen 200mg tablet - take 2 tablets by mouth every six hours for pain. R28's April 2025 MAR shows that R28 had not received nor requested any Tylenol or ibuprofen for pain. On 04/22/25 at 10:26 AM, reviewed progress notes dated 4/1/2025 - 4/22/2025 and no notes of dental pain or complaints mentioned in progress notes tab. On 04/22/25 at 10:40 AM, V4 (Certified Nurse Aide/CNA) stated R28 had not mentioned to her having a toothache. V4 stated facility has gotten a dental visit recently in last couple months, but doesn't remember who was seen. On 04/22/25 at 10:47 AM, V5 (Registered Nurse/RN) stated that R28 has mentioned a toothache and is supposed to see dentist next time they are on site. V5 stated dental services comes in house. V5 stated R28 has only mentioned dental pain once to her about one week ago. V5 stated when asked what she would do if someone complained of dental pain, V5 stated, I usually ask (V6, Social Services Director) in social services to put them on the list if they complain of dental pain. I don't remember if I called the doctor to order him something for pain or if I gave him anything for pain. On 04/22/25 at 10:52 AM, V2 (Director of Nurses/DON) stated that R28 had mentioned to her about 4-5 months ago that he had a toothache but has not heard about it since. On 04/22/25 at 10:54 AM, V6 stated (name of a dental provider) is who provides dental services. She said that they were just in at the end of the month, and they come in once every 3 months. V6 stated, I don't think they take Medicaid. I will call and ask them and get back to you. On 04/22/25 at 11:10 AM, V6 stated she had called and sent a voice mail to (name of a dental provider) dental services and asked them to return her call. On 04/22/25 at 2:05 PM, V6 stated that she had called (name of a dental provider) and they stated that they would pick up R28 up as a patient. She said that (name of a dental provider) would try and see R28 sooner than their next scheduled visit but did not give a specific date. She said that 4 months ago R28 told staff that he was experiencing tooth pain. He was then referred to (name of a dental provider) dental at that time. R28 had told (name of a dental provider) dental that he only made fifty-eight dollars a month, and they said that they couldn't take him. V6 stated that she wasn't in her current position in April 2024 when R28 had initially saw dental and been referred to oral surgery. She said she didn't know anything about resident's toothache at that time, but she agreed that the facility should have made the referral to oral surgery much sooner. On 04/22/25 at 2:17 PM, V2 stated she didn't know anything about the dental referral in April 2024. V2 stated, As far as the Oragel order for (R28) in December 2024 that's the first time I've heard of it, and I notified social services at that time. I would expect the dental referral made in April 2024 to have been made much sooner. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/22/25 at 2:21 PM, V1 (Administrator) stated she didn't start until August 2024. She doesn't know anything about the oral surgeon referral made in April 2024. She stated that it should have been followed up on sooner, though. The facility's dental policy dated 12/2024 states, Routine and emergency dental care is available. Should a resident need emergency dental care, the dental provider shall be notified so that arrangements for the emergency care can be made. Dental services include services needed to treat an episode of acute pain in teeth, gums, or palate; or any problem of the oral cavity appropriately treated by a dentist that requires attention.

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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. 41610 Based on interview, observation and record review the facility failed to provide the correct portion size of meat for altered textured diets for 9 (R1, R7, R12, R15, R16, R17, R25, R27, and R35) of 12 residents reviewed for altered textured diets in a sample of 32. Findings include: On 04/21/25 at 12:00 PM during lunch time V10 (Cook) served a #16 scoop (2 ounces) of pureed turkey and a #16 scoop (2 ounces) of mechanical soft turkey onto the trays for multiple residents that included R1, R7, R12, R15, R16, R17, R25, R27, and R35. The facility spreadsheet dated week 3 Monday documents the lunch meal should include: mechanical soft: 3 oz (ounces) and (ground) seasoned turkey pot roast, #8 scp (scoop) mashed potatoes, 2 oz L (liquid) gravy, 4 oz s (solid) green beans, 1 sq (square) cornbread, and 1 sq (square) frosted cake. The pureed diet documents: 1 pur (pureed) seasoned turkey pot roast, #8 scp mashed potatoes, 2 oz L gravy, #12 scp pur green beans, #16 scp pur cornbread, #12 scp pur frosted cake. The facility recipe for pureed seasoned turkey pot roast dated 2025-2025 Week 3 Monday- noon meal, documents: portion: #8 scp (3.75 ounces/1/2 cup). The untitled facility document dated 04/21/25 signed by V9 (Dietary Manager) documents: R1, R27, and R35 receive a puree texture diet and R7, R12, R15, R16, R17, and R25 receive a mechanical soft texture diet. On 04/24/25 at 10:33 AM, V9 stated on 04/21/25 the spreadsheet indicated 3 oz of turkey should have been served to the mechanical soft textured diet and the pureed diet should have received the #8 scoop which is 3. 75 ounces or a half a cup. Serving 2 ounces of meat was incorrect and she does not know why she (V10) served that amount.

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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** 41610 Based on interview and record review the facility failed to administer vaccinations resident previously had consented for, for 2 residents of 5 residents (R29 and R35) reviewed for immunizations in a sample of 32. Findings include: 1. R29's Admission record documents an admitted [DATE] with diagnoses including: protein calorie malnutrition, deaf/nonspeaking, major depressive disorder, adult failure to thrive, anxiety disorder, anorexia nervosa, and vitamin D deficiency. R29's Physician Order Sheet documents an order for: immunization: may have annual flu vaccine with consent unless contraindicated with an ordered date of 05/09/24 and end date listed as 'indefinite.' On 04/24/25 at 3:00 PM R29 who was alert and oriented to person, place and time stated, he has never signed a consent for influenza. R29 stated that he wouldn't mind getting the influenza vaccine. R29 stated he has never received the influenza vaccine since he has been at the facility. R29's Patient Consent form or Seasonal Influenza Vaccination dated 03/18/24 signed by V20 (family) documents: a check mark in front of the statement, I consent to receive the Seasonal Influenza Vaccination. On 04/22/25 at 2:32 PM V1 (Administrator) stated, she does not know how or why R29 would have a consent form that was signed prior to his admitted . R29's electronic immunization record for influenza vaccination documents: a confirmation date of 10/17/24 with immunization status of pending listed. R29's Medication Administration record dated 10/01/24 - 10/31/24 does not document any influenza vaccination administered. On 04/23/25 at 9:28 AM, V1 (Administrator) stated, R29 did not get his influenza vaccination in November 2024 when the clinic was present due to his insurance denied the vaccination. She is not for sure what the facility's policy is to do if the insurance denies, and the resident has not received the vaccination. R29 has still not received the vaccination. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility document dated 09/22 titled, Infection Prevention and Control Manual Resident Immunizations and Vaccinations documents: policy; 1. It is the policy of this facility that all residents will be offered immunization against influenza, 7. The timing of vaccination is in the fall and winter with only 1 dose required - the end of September and throughout October are ideal. Procedure: 4. Every new admission and existing resident are screened using the criteria contained within the standing protocol and based on the ACIP (advisory committee on immunization practice) and CDC (Center for Disease Control and Prevention) recommendations for influenza, 7. If the resident or resident representative elect to receive the influenza vaccine, the obtain informed consent with the respective form, 12. If the resident chooses to be immunized, then order the influenza vaccine, 14. If resident is afebrile and has no moderate to severe acute illness, then proceed with vaccination, 15. Administer the vaccine via the specified route, IM (intramuscularly) or intranasally, per manufacturer's recommendations, respectively, 16. Document in the resident's medical record and on the immunization record: a. education was provided b. specific medication or vaccine, c. manufacturer, lot number and expiration date d. route of administration e. site of injection f. date and time the vaccine was given g. who administered the vaccine h. any adverse reactions, 17. Complete vaccination billing log 18. Observe for side effects. 20. A record of vaccination will be placed in the resident's medical record and in their vaccination record. 2. R35's Admission Record documents a admitted [DATE] with diagnoses including: osteomyelitis of vertebra, severe protein calorie malnutrition, type 2 diabetes mellitus, dementia, and adult failure to thrive. R35's Pneumonia Vaccination Consent form dated 03/06/25 contains the statements: I consent to receive the Pneumococcal vaccine (PCV15), I consent to receive the Pneumococcal vaccine (PCV20), I consent to receive the Pneumococcal vaccine (PPSV23) checked. On 04/22/25 at 2:30 PM, R35's (PPSV23) pneumococcal vaccination vial was observed in the refrigerator in the medication room dated 03/10/25. On 04/23/25 at 10:15 AM, V5 (Registered Nurse) stated the date on R35's pneumococcal vaccination is the date it was received which was 03/10/25. On 04/23/25 at 9:28 AM, V1 (Administrator) stated R35 also had complications for her pneumococcal vaccination and insurance. V1 stated R35 has a consent for the pneumococcal vaccination signed on 03/06/25 and R35's pneumococcal vaccination is in the medication room dated 03/10/25. V1 stated she does not know why R35 has not received the vaccination she should have. On 04/24/25 on 1:47 PM, V2 (Director of Nursing) stated they do not have a policy for pneumococcal vaccinations, they just follow the CDC guidelines.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 41610 Based on observation, interview and record review the facility failed to provide at least 80 square feet of living space for 4 of 4 resident (R10, R12, R27 and R30) reviewed for room size in a sample of 32. Findings include: 1. On 4/23/25 at 11:25 AM, V7 (Maintenance) accompanied by this surveyor measured R12 and R27's room. The room measured 11 feet 9 inches by 12 feet 7 inches, total square feet = 151.13 (75.57 square feet per resident bed). The room contained 2 beds, 2 nightstands and 1 inset dresser. The measurements did not include the inset dresser area. On 4/23/25 at 11:47 AM, R27 who was alert to person, place and time stated her room size is ok and has no complaints. On 4/23/25 at 11:35 AM, R12 who was alert to person, place and time stated her room is ok and they have enough room. 2. On 4/23/25 at 11:30 AM, V7 accompanied by this surveyor measured R10 and R30's room. The room measured 12 feet 3 inches by 11 feet 9 inches, total square feet = 146.37 (73.19 square feet per resident bed). The room contained 2 beds, 2 nightstands, 1 inset dresser and 1 additional dresser. The measurement did not include the inset dresser area. On 4/23/25 at 11:32 AM, R30 who was alert to person, place and time, while in her room, stated she was ok with her room and had no complaints. On 4/23/25 at 11:32 AM, R10 who was alert to person, place and time, while in her room stated, They could use more room, but it's ok. When asked about the size of her room. On 4/23/25 at 11:56 AM, V1 (Administrator) stated rooms 1-18, 20-25, and rooms 30-33 were all waivered rooms that did not meet the 80 square feet per resident bed requirement. V1 stated these rooms were Medicaid certified. A facility Midnight Census Report provided by the facility on 4/21/23, documents that R10, R12, R27 and R30 reside in the rooms observed and measured by V7. Inquiries made regarding the size of the waivered rooms during the survey from 4/21/25 to 4/24/25, found no concerns or negative interviews from residents or families of residents who reside in the waivered rooms. Review of 6 months of Resident Council meeting minutes indicated no concerns related to the size of the waivered rooms.