

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/26/2025
NAME OF PROVIDER OR SUPPLIER  Resthave Home-Whiteside County		STREET ADDRESS, CITY, STATE, ZIP CODE  408 Maple Avenue Morrison, IL 61270	

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 - Minimal harm or potential for 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.  (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to protect a resident from abuse. This applies to one of three residents (R1) reviewed for abuse in the sample of six. The findings include: The facility face sheet for R1 shows diagnoses to include Alzheimer's Disease and Down Syndrome. The facility assessment dated [DATE] shows R1 to have moderate cognitive impairment and requires moderate assistance with her activities of daily living. The facility abuse investigation dated 8/14/2025 shows a staff Nurse (V3 Registered Nurse) was observed by staff yelling at R1 and then pulling her backwards down the hall as R1 was crying and yelling. An investigation was completed, and abuse was substantiated by the facility. On 8/26/2025 at 9:37 AM, V3 RN said she was completing the monthly medications change over to the medication cart at the nursing station on 8/14/2025. V3 said R1 was sitting at the nursing station as she often does, but R1 was trying to talk to V3 and this was very distracting to V3. V3 said she asked two other staff if they would move R1 to another area so she could complete her task safely, but R1 refused each time to leave the station and continued to disrupt her. V3 said she messed up and yelled at R1 and then tried to push her away from the nursing station, but R1 put her feet down and was refusing to leave the area. V3 said she turned R1 around in her wheelchair and pulled her backwards to another area of the facility. V3 said R1 didn't want this to happen, but V3 said she did it anyway. On 8/26/2025 at 11:20 AM, V4 Certified Nursing Assistant (CNA) said she was waiting at another nursing station to get report on 8/14/2025, when she heard R1 yelling and screaming. V4 said she ran over to the other station and saw V3 dragging R1 backwards in her wheelchair. V4 said R1 was yelling and crying. V4 said she ran to get R1 away from V3 and V3 just walked away from the situation. On 8/26/2025 at 12:42 PM, V5 CNA said she was at the nurses' station after the incident with V3 on 8/14/2025. V5 said V3 told her she was overwhelmed with the medication switchover and listening to R1 talk and ask so many questions. V3 told V5 she had asked other staff to get R1 away from her but R1 refused to go so she [took matters into her own hands] and drug her backwards down the hall [kicking and screaming]. On 8/26/2025 at 2:43 PM, V6 CNA said on 8/14/2025 at shift change, she was with V3 at the nursing station and was asked by V3 to try and move R1 away from the nursing station. V6 said she tried several times, but R1 did not want to move. V6 said V3 told her to get R1 moved because she was not dealing with her tonight. V6 said she told V3 she couldn't get R1 to move, and she would ask another CNA to come try, but V3 went over to R1 and tried pushing her away from the desk, but R1 put her feet down. On 8/26/2025 at 3:37 PM, V8 CNA said she had just come into work at around 10:50 PM and was looking at the assignment sheet when V3 asked her to please remove R1 away from the nursing station. V8 said she tried but R1 did not want to leave the area. V8 said after trying a few times, V3 came over to the edge of the nursing station and yelled at R1 saying [I don't want to get mean, but I've asked you nicely], then V3 counted [1,2,3] very loud and then came over to R1 and tried to push her down the hall. V8 said R1 was yelling and crying and putting her feet down and grabbing at the wheels of the wheelchair trying to stop V3 from moving her. V8 said she went over to R1 and tried to keep her from falling or getting her fingers pinched and V3 turned the wheelchair around and was pulling R1 down the hall. Just then another staff came and took R1 away from V3. On 8/26/2025 at 12:12 PM, V2 Director of Nursing said she got a call that night from one of the nurses and CNA's telling me about what V3 had done to R1. V2 said she came to the facility right away and walked V3 from the facility and suspended her until an investigation could be completed. V2 said V3 was terminated from the facility after the investigation was completed. The facility abuse policy with a review date of 12/20/2024 shows the facility does not tolerate abuse or neglect of its residents. Residents will not be subjected to abuse from anyone including staff.</p>		