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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146177	A. Building B. Wing	02/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resthave Home-Whiteside County	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 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** Based on observation, interview and record review the facility failed to ensure residents were treated with dignity for 2 of 3 residents (R1, R2) reviewed for dignity in the sample of 13.The findings include:1. R1s admission record shows he was admitted to the facility on [DATE]. His 12/2/25 resident assessment and care screening shows he is cognitively intact. The census report shows he was moved on 11/22/25 from room in (zone 2) to room in (zone 1).On 2/14/26 at 9:12 AM, R1 said he was in another room in the facility and did not like to say anything, but he did complain about the staff. There are 2 members of the staff that other residents complain about too but did not know their names. He reported these staff were mean to him. Their attitudes were not good. They were physically rough with him when he was not doing what they wanted. He said the mistreatment escalated to the point of needing to change rooms. R1 said they do not take care of him anymore, since changing rooms. R1 said he would like them to not take care of him at all. On 2/14/26 at 2:10 PM, V12, R1s daughter, said R1 had reported a complaint of the evil twins to her, and requested they not provide care for him. V12 said she requested specifically they do not have any contact with him. She said they were unkind, and to the point he was refusing care, even with family in the room. V12 said anyone choosing to work as an aide is to deal with grumpy people and they need to know how to manage them and monitor their reactions to the situations. She said she reported the twins to V11 social service, and he knew exactly who we were talking about. She said it bothered us they were aware of situations, and they are known in that way, and wondered why they are still working there. V12 said R1 did not like how he was treated, not with dignity or respect to the point of affecting his care. He would rather sit soiled than to have them in his room.On 2/14/26 at 11:18 AM, V11 said R1s family approached him and requested a room change to a different hallway. V11 said he did not know the reason. He said it was the daughter who spoke with him, and he believes it was due to a personality incompatibility with his current aides. V11 said he could not recall the names of the caregivers in question.On 2/14/26 at 11:39 AM, V9 Certified Nursing Assistant (CNA) said the twins were V3 and V4. They are also referred to as the sisters. There have been residents requesting they not provide care for them. One resident would rather sit in urine than have them assist with care. He would seek out help from staff on other hallways. V9 said she did report the situation, and he was moved to another hallway. The facility daily assignment sheets for February 1-12, 2026, show V3 and V4 were scheduled to work on zone 2 during their days to work.2. R2s admission record shows he was admitted on [DATE] and discharged on 12/29/25 after 6 days. His census report showed he resided in room on zone 2. His admitting diagnosis included sepsis following a hip replacement.R2 progress notes show on 12/29/25, V10, R2s wife, approached V11 and said she wanted to take him home. On 2/14/26 at 12:25 PM, V11 said R2s family did have some concerns regarding his stay, and he guided them through the grievance process. Their concerns were related to laundry not returning to his room, not enough fluids on his meal trays, and there (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were concerns with some of the caregivers. Her concern was the staff were not going at R2s pace, they were moving too fast for his needs. V11 said he did not recall the staff names. The 12/29/25 grievance form completed by V10 documents she witnessed staff not taking their time or listening to R2 when the speed at which the staff was moving him and causing him some discomfort and causing him to sit down at a speed that needed to be slower. She reported them as The Twins and were the most frequent staff members giving cares.On 2/14/26 at 1:30 PM, V10 said there were several issues with R2s stay in the facility. She said R2 had a hip replacement on 12/9/25 and had sepsis days after the surgery. He was admitted to the facility for antibiotics and therapy. She voiced complaints with dietary and laundry and said then there were the Twins, they were the worst. She had to remind them of the recent hip replacement; they would jerk him out of bed without letting him get his bearings, and plop him into a wheelchair and let him fall hard onto the toilet. She said they just did not seem to care. She said R2 was scared to speak up, he just wanted to go home. The twins just had an attitude. V10 said the mistreatment was over time, they did not treat him with dignity, they were rough and rude. She said that was pretty much the reason R2 went home early. He was afraid of retaliation if he were to speak up. She reported the situation to V11 because nobody should feel that way.On 2/14/26 at 12:26 PM, V2 Director of Nursing said she was aware of R2s concerns with V3 and V4. We told them to take the time to meet the residents' needs, and make sure to give them time. She did some sensitivity training. She said V3 and V4 are very good, they follow the rules, and they love the residents. She said R1 was not a fan of them either, and his family asked for V3 and V4 to not be his care givers, so he was moved to zone one. She said V3 and V4 are very task oriented. V2 said she spoke with R1 and R2 and all we were hearing for their complaint was they were short, not lovey dovey, and do not come across as warm and fuzzy. On 2/14/26 at 1:50 PM, V3 said she works in zone 2 every day. She was not aware of any residents she was not to provide care for and never had any issues with R1 or R2. On 2/14/26 at 1:30 PM, V4 was unable to be reached, and her voicemail was full, and unable to leave a message.On 2/14/26 at 2:30 PM, V1 Administrator said she knew there had been a couple of residents with personality complaints and had to move R1 to zone 1. She was also aware R2 had voiced concerns and filed grievance.The facility's 10/1/15 policy for Dignity documents each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. 1. Residents shall be treated with dignity and respect at all times. 2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.