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	06/09/2026

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 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 ensure a resident was free from resident-to-resident abuse for 1 of 3 residents (R1) reviewed in the sample of 6. This failure resulted in R1 repeatedly being yelled at, cursed at, and called names by R2.The findings include:R1's face sheet showed he was admitted to the facility [DATE] with diagnoses to include Parkinson's Disease without dyskinesia, hypertensive heart disease with failure, chronic congestive heart failure, peripheral vascular disease, and symptoms and signs involving cognitive functions and awareness. R1's [DATE] facility assessment showed he has moderate cognitive impairment and requires moderate assistance from staff for most of his cares.R1's care plan initiated [DATE] showed, [R1] has a diagnosis of Parkinson's Disease affecting his cognition. R1's care plan initiated [DATE] showed, [R1] has impaired cognitive function. [DATE] - Code Alert added to wheelchair (device to set off an alarm at the doors to alert staff if resident is trying to exit the facility). R1's care plan initiated [DATE] showed, . He has Parkinson's Disease, causing impaired cognition. [R1] has a female friend that he spends time with at the facility. [R1] has a special friend that he spends most of his time with. Both families are good with this arrangement.R2's face sheet showed she was admitted to the facility [DATE] with diagnoses to include polyarthritis, hypertension, dementia without behavior disturbance, muscle weakness, pain in right hip, pain in left knee, and depression. R2's facility assessment dated [DATE] showed she has moderate cognitive impairment and requires substantial to maximum assistance from staff for most cares. R2's care plan initiated [DATE] showed, . [R2] has a special male friend at [the facility] that she spends most of her time with. R2's care plan initiated [DATE] showed, [R2] at times will raise her voice at her male friend/peer. Diagnosis of Dementia. [R2] will decrease frequency of raising her voice at peer through the review date. When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. [NAME] B/T (Behavior Tracking) if this resident is witnessed raising her voice/yelling at peer(s)/her male peer/friend. There have been no changes to the interventions on this care plan since it was initiated [DATE]. R2's [DATE] Behavior Note entered at 7:30 PM showed, Resident resting in bed, her s.o. (significant other) [R1] is also a resident present in the room visiting. [R2] ordering him to perform small tasks in room, very demanding and talking down to significant other. CNA (Certified Nursing Assistant) heard from hallway [R2] tell him [R1] that he was F*cking stupid and attempted to de-escalate situation and separate couple. [R2] then started yelling at CNA telling her that [R1] was not ready to leave. CNA politely informed resident that she was talking to significant other [R1] and asked him again if he wanted to get ready for bed. [R1] declined, CNA reported situation to this nurse. 7:45 PM This nurse then entered room, [R1] still doing small tasks. [R2] had decreased negative verbalizations in the presence of nurse. This nurse asked [R1] if he was doing O.K. or if he would like to get ready for bed. He stated he would but just wanted to finish last chore and it would only be 5-10 more minutes. [R2] agreed to him leaving then. R1's [DATE] Behavior Note entered at 9:27 AM showed, Resident and other resident [R2] have been found multiple (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 0600 Level of Harm - Actual harm Residents Affected - Few	times in each other's rooms, screaming profanities and yelling at one another using abusive language. Even after redirection, the two continue to argue and cause a scene. Other residents and visitors near can hear this language and behavior and have shown concern. This nurse will speak with the social worker to discuss a plan of action regarding behaviors.R2's [DATE] Behavior Note entered by DON (Director of Nursing) at 12:57 PM showed, This nurse was at the nurse's station when she heard loud shouting. I got up to check on resident and find the source of yelling. As I got closer to her room, I could hear this resident yelling ?Behind you! By your elbow! Don't you know where your elbow is?', this nurse entered room of resident and noticed her male companion was also in the room, sitting in her recliner. This nurse asked, ?[R2], is there something you need help with? I can hear you yelling at [R1] from the desk.R2's [DATE] Behavior Note entered at 4:48 PM showed, Resident in room and staff at nurse's desk, was able to hear resident yelling and crying. Peer resident in room at the time. Staff heard peer resident tell [R2], ?I can't help you with that.' Resident then cried out loudly ?Just do it.' Staff entered room and separated the 2 residents. Resident wanted to be boosted back in wheelchair. R1's [DATE] Behavior Note entered at 4:54 PM showed, Resident was in a peer resident room. Yelling was heard coming out of the room. Peer resident was yelling at this resident to perform a task that he is unable to do. Resident was heard telling peer resident ?I can't help you with that.' This resident was assisted out of peer resident room to his own room. Resident told CNA (Certified Nursing Assistant) 'He can't drive that thing. He was able to drive it yesterday and today he can't.' CNA told resident that peer resident was a woman and resident agreed and then continued to refer to peer resident as a ?he'.R2's [DATE] Behavior Note entered at 3:20 PM by V2 DON showed, Resident noted yelling several times at male friend throughout shift. This nurse intervened and assisted resident with her requests when possible, however, sometimes her requests were unclear. Both this resident and male friend encouraged to use call light to ask staff for assistance with tasks. R2's [DATE] Behavior Note entered at 2:48 PM showed, While this nurse was receiving AM (morning) report at approximately 6:10 AM, this nurse and other staff could hear resident yelling at another resident, that she is in a relationship with. Resident was verbally yelling insults at the other resident, as he did not understand what she was asking of him. This nurse went into resident's room and separated the two. Later in the morning, resident was being pushed down the hallway by the resident she is in a relationship with. This nurse could hear resident cussing at him about her feet not being on her foot pedals the right way. As the other resident was trying to assist resident with her foot placement, resident yelled at him, ?You shit for brains! Not like that!' This nurse immediately intervened and separated the two for a second time, asking the male resident to go ahead to his room and this nurse would assist resident in what she needed. This nurse explained to resident that this nurse would be letting social services know about this behavior, as it had been on going on at this point for nearly half the shift, and is not fair to the other resident. Resident looked at this nurse and yelled, ?The shit you are!' This nurse did report verbal abuse issues to. [V3 Social Services Director]. Later in the shift, this nurse again had to intervene and separate these residents, as resident again began to verbally assault her boyfriend with cuss words and derogatory statements.R2's [DATE] Behavior Note entered at 3:03 PM, Resident was in her room with another male, resident, and was overheard by staff, yelling at him. This nurse approached resident's room and inquired of the happenings. Resident states, ?Oh go away, he's just too dumb to understand what I am asking him to do.' This nurse observed male resident holding out a rag to resident, and he states, ?Here, this is what you asked for.' Before this nurse could intervene, resident yelled, ?I asked you for a rag! What are you blind?!' This nurse informed resident that the male resident, indeed had and was holding out to her, the rag that she had asked him to get for her. Resident became upset and started to cuss at this nurse and the male resident. This nurse promptly removed the male resident from resident's room and placed him into his own room. Later in the afternoon, this nurse was walking by resident's room and overheard her yelling, ?You're too stupid to understand!' This nurse entered resident's room and observed the male resident holding out a book to resident. This nurse inquired of the issue. Resident (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	states, I asked him for that book, and he can't understand anything!' The male resident states, ?You told me a book, this is the one I found.' This nurse explained to the resident that what she was doing is verbal abuse, and it is not acceptable to treat another person this way, especially when they are trying to help. Resident states, ?The shit it is!' This nurse informed the male resident that it was time to leave the situation. The male resident agreed to allow this nurse to push him in his wheelchair back to his own room. When this nurse attempted to assist the male resident, resident put her feet straight out in front of the male resident's wheelchair and began to kick her feet up and down, in an attempt to keep the male resident from leaving. This nurse asked resident to please not put herself or the male resident at risk for injury, and resident stopped this behavior.On [DATE] at 10:32 AM, V7 CNA (Certified Nursing Assistant) said, [R1] and [R2] have been in a relationship for a couple years. They do not get along; they argue quite a bit. She gets frustrated because she wants him to do everything for her. This happens every day. I think it is abusive. I think they should probably be moved so they aren't so close to each other. We report it but administration knows, they have seen it.On [DATE] at 10:38 AM, V5 LPN (Licensed Practical Nurse) said, [R2] yells at [R1], she calls him an idiot and cusses at him. He puts up with a lot and he still does a lot for her. Both are confused, him more than her. Sometimes we go in and suggest that they separate for a while. Sometimes he returns yelling back if it's been a lot and that is when we go in and suggest they take some time apart. I feel that the things she says are abusive to him.On [DATE] at 11:13 AM, V4 LPN said, It is known throughout the facility that they are companions. On and off, she is very verbally aggressive and abusive to him. I myself, have separated them multiple times, in fact this weekend I had to separate them again . I know they both have failing cognitive faculties. For instance, the last two times I witnessed verbal abuse from [R2], [R1] was trying to help her, and he was doing word for word what she was asking him to do. She was just insulting his intelligence. She was asking him a couple weeks ago to do something, and she called him ?shit for brains'. so I went and separated them. Then this weekend, the same scenario happened but they were in her room. She was asking him for a rag and when I was in there, he was handing her the rag, and she was yelling at him. I told her that he was handing her the rag. I said, ?[R2] apparently you are having a bad day, but I'm not letting [R1] sit here and take this. He doesn't deserve this.' Then later in the day, right before church, I heard a commotion, and she was yelling at him again. He was holding a book out to her, and she was just verbally insulting him all over again. I said, ?[R1], I'm so sorry, you are very tolerant, but I'm separating you again and I want you to stay apart until at least church.' V4 said when she went to remove R1 from R2's room, R2 put her feet up straight out and started kicking her feet to try and keep her from removing R1. V4 said she told R2 that it was dangerous to keep kicking her feet like that and could hurt R1 or herself doing this. V4 said they are reporting a lot of verbal aggression from R2 towards R1 to Social Services. V4 said she requested to have R1's room moved to provide some separation between R1 and R2. V4 said there was a room open not too long ago in the same hall, but further down. V4 said that way R1 and R3 wouldn't be right next to each other. V4 said she has gone to V3 (Social Services Director) at least 3 times suggesting room changes. V4 said V3 told her when they do R1 and R2's care plan meeting they talk about things and that some of these things were being addressed but V4 said it continues to happen. V4 said she has not reported anything to V1 (Administrator) because V3 (Social Services Director) is on the Abuse Committee. V4 said she feels Administration is 100% aware of this situation between R1 and R2. V4 said, This has been going on for months and months. every episode is not documented as often it is happening, because it happens so frequently that most of our days would be spent documenting [R2's] behavior. God bless that man (R1), he is the most tolerant man and there was one day last week I think it was that he finally bit back and told her to stop yelling at him and use her damn eyes. I separated him from [R2] at that point, even though it is usually me separating [R2] from him. Her behavior is absolutely abusive. She is constantly taking shots at his intelligence. She cusses at him. When he is raising his voice back at her, that is when I can tell that it's affecting him, otherwise, he just has a flat affect and sits there. This can definitely be heard through the halls. It is (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	very loud. It goes on during mealtimes too now. When I report it, I'm told to keep documenting it because they go over these things in their care plans. [V3] told me that all I can do is document it. On [DATE] at 11:31 AM, V6 LPN said, [R2] usually has [R1] attempting to do things for her like turn her call light on, pull her back in the chair, fix her clothes, things like that and physically he can't do it. A lot of times he doesn't understand what she is trying to say and gets confused when she yells at him. She yells a lot of different things at him, calls him names, tells him he is stupid because he isn't understanding. She has sworn at him. I would consider what she says and when she yells at him as abusive at times. Administration is aware, I have said something to the [V2] DON in the past and from what I understand another nurse has reported it to [V3 Social Services Director]. I think [V1 Administrator] and [V3 Social Services Director] share the abuse coordinator title. Pretty much [V2] said to separate them until they stop. I will separate them and take [R1] to his room but [R2] will immediately start yelling out for him, and because their rooms are across the hall from each other he hears her and goes right back. It wasn't a specific situation I reported to [V2], just that it was escalating. I feel like it has escalated because he is declining mentally, so he is not comprehending what she is asking. It's getting worse because it is harder for him to understand. A lot of times he doesn't even understand where he is at or what he is doing. I think he sun downs; I work second shift. He talks about being on his way to New York because his grandmother died and he has to settle their estate, he wants to rent his room for another night, things like that. I can tell when it is affecting him because sometimes you can hear the tone in his voice change when she is yelling at him, he won't yell but he will get a little gruffer in his response.On [DATE] at 12:50 PM, V3 Social Services Director said, [V1 Administrator] and myself are the abuse coordinators. [R1] and [R2] both came in at separate times, but they made a connection a couple years ago. I don't know how they define the relationship, but we would see them as a couple or two very, very close friends. They are together throughout the day at meals, activities, events, that sort of thing. How they get along fluctuates. There are some tensions like any relationship. There are arguments between the two of them, but generally speaking, they have a very respectful relationship. [R1] and [R2]'s cognition is low as far as retention and memory. I would have they have low cognition. Behaviors have been reported to me, from time to time there is tension or stress, and they tend to separate or staff separate them as well. I saw those notes today. I never heard or witnessed that verbal aspect as far as firsthand or being there in the moment. She does get frustrated, just in general and gets frustrated with him as well. Staff report general stress in the moment. If she is trying to say something and he isn't quite getting it, they intervene and try to help and fix what he needs and that fixes it in the moment. I don't think he is understanding what she is trying to say, or she isn't expressing it as well as she thinks she is. If she is cursing at him or saying derogatory things, that wouldn't be a good thing. I don't have recollection of those details being shared with me. That would require a 1:1 conversation. If it was reported that she was cursing and yelling at him, we would start an abuse investigation. I don't have recollection of any one particular incident. I would say they should separate the individuals, reduce or alleviate the stress in that particular moment. When things have been shared with me about [R1] and [R2], staff have already intervened. That is something that we do ongoing. To prevent this from happening, we are trying to meet the needs of the individuals of course, being aware of where individuals are at and if they are in a certain situation that is stressful maybe we are stopping and keeping an eye on things, it depends on the moment and the situation. We do behavior tracking. Social Services generally are putting the behavior tracking into the computer. we have our monthly psychotropic medication meeting, and we review behavior tracking, medication dosages and changes. During the meeting if we see behaviors documented, we discuss it from a medication standpoint and review to see if there are any interventions from a behavior standpoint. We discuss environmental changes, such as rearranging the room, changing get up times, or room changes. We don't document those meetings, we have them once a week, so we review everyone on a monthly basis and as needed of course. I don't recall discussing any environmental changes being discussed for [R1] or (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	[R2]. I don't know how often these behaviors are occurring, I would have to go back and look at the tracking. During the meeting we don't look at the nursing notes, we look at the medications. There are 3 core people in that meeting, [V1], [V2], and myself.On [DATE] at 2:35 PM, V2 DON (Director of Nursing) said, I'm part of the behavior committee. We break it into three parts, so everyone is done quarterly. We go through their medications and behaviors together. We talk about gradual dose reductions during that time and discuss any sort of behaviors that people are having. Even if they aren't in the group we are discussing that doesn't mean we can't bring it up with something that is happening that is disruptive. At times we talk about interventions, what is the cause of the behavior, what is the root cause, and what we can do to make sure that whatever the behavior isn't a safety risk. We are also talking about what we tried, what could we do additionally, how severe the behavior is, and if it warrants intervention. Any new interventions would be added by the Care Plan nurse. [R1] doesn't really have any behaviors, he is pleasantly confused. [R1] and [R2] bicker, she yells and wants things done for her. He wants to just serve her. I have gone in to find out what she needs, and I'll help her. It is always such piddly tasks, like picking something up off the floor. I don't think [R1] understands what she is asking him to do, sometimes I don't understand what she is asking for either. So, I think a little of her confusion comes in there too. It happens in the room most of the time. So far what we have talked about for them is that if we hear it going on, go in and do whatever it is she needs, and check to see if [R1] is okay. I have taken him out of the room, but he will go right back in. If it is name calling or cursing at him, that would be abusive. (V2 reviewed R2's [DATE] Behavior Note) This nurse should have reported this, I read it the other day during morning meeting, and I wanted to talk to this nurse. She should have contacted the abuse coordinator. (V2 reviewed R2's [DATE] Behavior Note) There should have been an abuse investigation started on [DATE] from this note. I don't remember if I saw the [DATE] note. (V2 reviewed the [DATE] Behavior note that she entered in R2's chart) I don't consider her yelling at him to be verbal abuse, I took it as ?frustrated'. That day, she did not call him any names. It was on [DATE] that I first told [V3] about their bickering. I told [V3] I was down there and that we should probably move [R1]. I think it has been an issue for a while but when I entered my last note [DATE], I told [V3] the poor man (R1) doesn't understand what she is asking. [V3] asked me if I had any ideas and I told him ?Out of sight, out of mind'. [R2] calls for him so I think if we move him and leave her there and start having them eat in separate dining rooms, I think they would be fine. At that time, he said okay and that we could talk to the family about it. They haven't been moved. Reviewing the behavior tracking, it appears concerning. Room changes were never discussed in our meeting.On [DATE] at 3:15 PM, V1 Administrator said, The abuse coordinator role is shared by me and [V3]. We usually go by an on-call calendar. One of us is designated every day to be on call. Staff can come to any of us. It should be immediate reporting if something happens. There has been some aggravation between the two of them (R1 and R2) and as both of their dementia and cognitive deficits have gotten worse, the behaviors are getting worse. Nothing has been brought to my attention as far as a level of abuse. It would be something down the line we could do, is to move one of them if the behaviors have continued. The aggravation seems to be getting worse, and we may have to consider moving them to different sides of the building. Right now, they are right across the hall from each other. For the most part, their relationship has been very positive. It has been just recently that the aggravation has gotten worse. Verbal behaviors are considered abusive if they are using profanity, yelling, name calling, or derogatory statements. If staff were to witness any of those, I would expect a phone call to be made so an abuse investigation could be started immediately. (V1 reviewed [DATE] Behavior Note showing V3 was notified.) [V3] should have reported that there was an abuse allegation. (V1 reviewed the Behavior Tracking documentation.) It is concerning for him to be getting yelled at like this. The Behavior Meetings do not include enough detail. The Social Workers run these meetings. They should be reviewing behaviors and reporting them. I would expect these behaviors to be identified, investigated, and the resident should be protected.The facility's policy and procedure reviewed [DATE] showed, Preventing and (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Reporting Abuse/Neglect; Purpose: To provide a safe environment and protect residents and the facility. Policy: [The facility] does not tolerate abuse or neglect of its residents. Each resident will be free from abuse, neglect. in any manner that would demean or humiliate them. Resident will not be subjected to abuse by anyone, including but not limited to, facility staff, other residents. Definitions and criteria used to determine abuse or neglect: . 3. Verbal or psychological abuse, which may include but is not limited to the use of words, signs, or gestures to intimidate, demean, curse, harass, punish, humiliate, cause emotional anguish or distress, ridicule, or threaten harm to the resident, or words, signs or gestures or actions that the person knows for regressive behavior by that resident. Procedure: . The interdisciplinary team will formulate care plans to address needs and interventions of those residents with a history of or potential for aggressive behavior as well as those at a higher risk due to total dependence for cares and significant cognitive/communication deficits. Any staff member who witnesses or suspects abuse or neglects must contact the facility's abuse coordinator. Should the Administrator not be named abuse coordinator on the date of witnessed or suspected abuse or neglect, then the contacted abuse coordinator, who would include either Director of Nursing or Social Services Director must contact Administrator immediately. In the absence of the ADM (Administrator), DON, or SSD (Social Services Director), the incident shall be reported to a charge nurse, who will notify one of these abuse coordinators immediately. The Administrator, Director of Nursing and/or Social Services Director will interview and/or examine the resident involved and initiate an investigation. When the alleged perpetrator is another resident of the facility, that resident shall be evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. Referral to the Social Work Consultant, Ombudsman or other appropriate personnel to assist in the evaluation or referral will be considered.

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F 0610 Level of Harm - Actual harm Residents Affected - Few	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 to ensure abuse allegations were investigated for 1 of 3 residents (R2) reviewed for abuse in the sample of 6. This failure resulted in R2 repeatedly yelling at, cursing at, and calling R1 names. The findings include:On 6/9/26 at 9:30 AM, V1 (Administrator) said, The last abuse investigation was done in August 2025 and was not related to [R1] or [R2].R1's face sheet showed he was admitted to the facility 9/15/23 with diagnoses to include Parkinson's Disease without dyskinesia, hypertensive heart disease with failure, chronic congestive heart failure, peripheral vascular disease, and symptoms and signs involving cognitive functions and awareness. R1's 6/2/26 facility assessment showed he has moderate cognitive impairment and requires moderate assistance from staff for most of his cares.R1's care plan initiated 9/18/23 showed, [R1] has a diagnosis of Parkinson's Disease affecting his cognition. R1's care plan initiated 9/16/23 showed, [R1] has impaired cognitive function. 3/11/26 - Code Alert added to wheelchair (device to set off an alarm at the doors to alert staff if resident is trying to exit the facility). R1's care plan initiated 6/3/25 showed, . He has Parkinson's Disease, causing impaired cognition. [R1] has a female friend that he spends time with at the facility. [R1] has a special friend that he spends most of his time with. Both families are good with this arrangement.R2's face sheet showed she was admitted to the facility 3/3/23 with diagnoses to include polyarthritis, hypertension, dementia without behavior disturbance, muscle weakness, pain in right hip, pain in left knee, and depression. R2's facility assessment dated [DATE] showed she has moderate cognitive impairment and requires substantial to maximum assistance from staff for most cares. R2's care plan initiated 6/17/25 showed, . [R2] has a special male friend at [the facility] that she spends most of her time with. R2's care plan initiated 1/28/26 showed, [R2] at times will raise her voice at her male friend/peer. Diagnosis of Dementia. [R2] will decrease frequency of raising her voice at peer through the review date. When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. [NAME] B/T (Behavior Tracking) if this resident is witnessed raising her voice/yelling at peer(s)/her male peer/friend. There have been no changes to the interventions on this care plan since it was initiated 1/18/26. R2's 9/21/25 Behavior Note entered at 7:30 PM showed, Resident resting in bed, her s.o. (significant other) [R1] is also a resident present in the room visiting. [R2] ordering hm to perform small tasks in room, very demanding and talking down to significant other. CNA (Certified Nursing Assistant) heard from hallway [R2] tell him [R1] that he was F*cking stupid. R1's 11/7/25 Behavior Note entered at 9:27 AM showed, Resident and other resident [R2] have been found multiple times in each other's rooms, screaming profanities and yelling at one another using abusive language. Even after redirection, the two continue to argue and cause a scene. Other residents and visitors near can hear this language and behavior and have shown concern. This nurse will speak with the social worker to discuss a plan of action regarding behaviors.R2's 5/14/26 Behavior Note entered at 2:48 PM showed, While this nurse was receiving AM (morning) report at approximately 6:10 AM, this nurse and other staff could hear resident yelling at another resident, that she is in a relationship with. Resident was verbally yelling insults at the other resident. This nurse went into resident's room and separated the two. Later in the morning, resident was being pushed down the hallway by the resident she is in a relationship with. This nurse could hear resident cussing at him about her feet not being on her foot pedals the right way. As the other resident was trying to assist resident with her foot placement, resident yelled at him, ?You shit for brains! Not like that!'. This nurse explained to resident that this nurse would be letting social services know about this behavior, as it had been on going on at this point for nearly half the shift, and is not fair to the other resident. Resident looked at this nurse and yelled, ?The shit you are!' This nurse did report verbal abuse issues to. [V3 Social Services Director]. Later in the shift, this nurse again had to intervene (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resthave Home-Whiteside County	408 Maple Avenue Morrison, IL 61270

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F 0610 Level of Harm - Actual harm Residents Affected - Few	and separate these residents, as resident again began to verbally assault her boyfriend with cuss words and derogatory statements.R2's 6/7/26 Behavior Note entered at 3:03 PM, Resident was in her room with another male, resident, and was overheard by staff, yelling at him. This nurse approached resident's room and inquired of the happenings. Resident states, ?Oh go away, he's just too dumb to understand what I am asking him to do.' . Before this nurse could intervene, resident yelled, ?I asked you for a rag! What are you blind?!' . Resident became upset and started to cuss at this nurse and the male resident. Later in the afternoon, this nurse was walking by resident's room and overheard her yelling, ?You're too stupid to understand!' . This nurse explained to the resident that what she was doing is verbal abuse, and it is not acceptable to treat another person this way, especially when they are trying to help. Resident states, ?The shit it is!' . On 6/9/26 at 10:32 AM, V7 CNA (Certified Nursing Assistant) said, [R1] and [R2] have been in a relationship for a couple years. They do not get along; they argue quite a bit. She gets frustrated because she wants him to do everything for her. This happens every day. I think it is abusive. I think they should probably be moved so they aren't so close to each other. We report it but administration knows, they have seen it.On 6/9/26 at 10:38 AM, V5 LPN (Licensed Practical Nurse) said, [R2] yells at [R1], she calls him an idiot and cusses at him. He puts up with a lot and he still does a lot for her. Both are confused, him more than her. Sometimes we go in and suggest that they separate for a while. Sometimes he returns yelling back if it's been a lot and that is when we go in and suggest they take some time apart. I feel that the things she says are abusive to him.On 6/9/26 at 11:13 AM, V4 LPN said, It is known throughout the facility that they are companions. On and off, she is very verbally aggressive and abusive to him. I have separated them multiple times, in fact this weekend I had to separate them again . I know they both have failing cognitive faculties. For instance, the last two times I witnessed verbal abuse from [R2], [R1] was trying to help her, and he was doing word for word what she was asking him to do. She was just insulting his intelligence. She was asking him a couple weeks ago to do something, and she called him ?shit for brains'. so I went and separated them. Then this weekend, the same scenario happened but they were in her room. she was yelling at him. I said, ?[R2] apparently you are having a bad day, but I'm not letting [R1] sit here and take this. He doesn't deserve this.' Then later in the day, right before church, I heard a commotion, and she was yelling at him again. V4 said they are reporting a lot of verbal aggression from R2 towards R1 to Social Services. V4 said she requested to have R1's room moved to provide some separation between R1 and R2. and that way R1 and R2 wouldn't be right next to each other. V4 said she has gone to V3 (Social Services Director) at least 3 times suggesting room changes. V4 said V3 told her when they do R1 and R2's care plan meeting they talk about things and that some of these things were being addressed but V4 said it continues to happen. V4 said she has not reported anything to V1 (Administrator) because V3 (Social Services Director) is on the Abuse Committee. V4 said she feels Administration is 100% aware of this situation between R1 and R2. V4 said this has been an ongoing issue for months and months and that every episode has not been documented as often it happening, because it happens so frequently that most of their days would be spent documenting R2's behavior. V4 said R2's behavior is abusive, and she is constantly taking shots at R1's intelligence and cussing at him. When I report it, I'm told to keep documenting it because they go over these things in their care plans. [V3] told me that all I can do is document it. On 6/9/26 at 11:31 AM, V6 LPN said, [R2] usually has [R1] attempting to do things for her like turn her call light on, pull her back in the chair, fix her clothes, things like that and physically he can't do it. A lot of times he doesn't understand what she is trying to say and gets confused when she yells at him. She yells a lot of different things at him, calls him names, tells him he is stupid because he isn't understanding. She has sworn at him. I would consider what she says and when she yells at him as abusive at times. Administration is aware, I have said something to the [V2] DON in the past and from what I understand another nurse has reported it to [V3 Social Services Director] . Pretty much [V2] said to separate them until they stop. I will separate them and take [R1] to his room but [R2] will immediately start yelling out for him, and because their rooms are across the hall from each other he (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	hears her and goes right back.On 6/9/26 at 12:50 PM, V3 Social Services Director said, [V1 Administrator] and myself are the abuse coordinators. [R1] and [R2] both came in at separate times, but they made a connection a couple years ago. I don't know how they define the relationship, but we would see them as a couple or two very, very close friends. They are together throughout the day at meals, activities, events, that sort of thing. How they get along fluctuates. There are some tensions like any relationship. There are arguments between the two of them, but generally speaking, they have a very respectful relationship. I would say they both have low cognition. Behaviors have been reported to me, from time to time there is tension or stress, and they tend to separate, or staff separate them as well. I saw the behavior notes today. I never heard or witnessed that verbal aspect as far as firsthand or being there in the moment. She does get frustrated, just in general and gets frustrated with him as well. Staff report general stress in the moment. If she is trying to say something and he isn't quite getting it, they intervene and try to help and fix what he needs and that fixes it in the moment. If she is cursing at him or saying derogatory things, that wouldn't be a good thing. (Reviewed Behavior Notes with V3) These particular details were not shared with me. These would require a 1:1 conversation.I would say they should separate the individuals and reduce or alleviate the stress in that particular moment. When things have been shared with me about [R1] and [R2], staff have already intervened. That is something we do on going, intervene. To prevent this from happening, we are trying to meet the needs of the individuals of course, being aware of where individuals are at, and if they are in a certain situation that is stressful maybe we are stopping and keeping an eye on things, it depends on the moment and the situation. We do behavior tracking.On 6/9/26 at 3:15 PM, V1 Administrator said, The abuse coordinator role is shared by myself and [V3]. We usually go by an on-call calendar. One of us is designated every day to be on call. Staff can come to any of us. It should be immediate reporting if something happens. There has been some aggravation between the two of them (R1 and R2) and as both of their dementia and cognitive deficits have gotten worse, the behaviors are getting worse. Nothing has been brought to my attention as far as a level of abuse. It would be something down the line we could do is to move one of them if the behaviors have continued. The aggravation seems to be getting worse, and we may have to consider moving them to different sides of the building. Right now, they are right across the hall from each other. For the most part, their relationship has been very positive. It has been just recently that the aggravation has gotten worse. Verbal behaviors are considered abusive if they are using profanity, yelling, name calling, or derogatory statements. If staff were to witness any of those, I would expect a phone call to be made so an abuse investigation could be started immediately. (V1 reviewed 5/14/26 Behavior Note showing V3 was notified.) [V3] should have reported that there was an abuse allegation. (V1 reviewed the Behavior Tracking documentation.) It is concerning for him to be getting yelled at like this. I would expect these behaviors to be identified, investigated, and the resident should be protected.The facility's policy and procedure reviewed 9/3/25 showed, Preventing and Reporting Abuse/Neglect; Purpose: To provide a safe environment and protect residents and the facility. Policy: [The facility] does not tolerate abuse or neglect of its residents. Each resident will be free from abuse, neglect. in any manner that would demean or humiliate them. Resident will not be subjected to abuse by anyone, including but not limited to, facility staff, other residents. Definitions and criteria used to determine abuse or neglect: . 3. Verbal or psychological abuse, which may include but is not limited to the use of words, signs, or gestures to intimidate, demean, curse, harass, punish, humiliate, cause emotional anguish or distress, ridicule, or threaten harm to the resident, or words, signs or gestures or actions that the person knows for regressive behavior by that resident. Procedure: . The interdisciplinary team will formulate care plans to address needs and interventions of those residents with a history of or potential for aggressive behavior as well as those at a higher risk due to total dependence for cares and significant cognitive/communication deficits. Any staff member who witnesses or suspects abuse or neglects must contact the facility's abuse coordinator. Should the Administrator not be named abuse coordinator on the date of witnessed or suspected abuse or (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	neglect, then the contacted abuse coordinator, who would include either Director of Nursing or Social Services Director must contact Administrator immediately. In the absence of the ADM (administrator), DON, or SSD (Social Services Director), the incident shall be reported to a charge nurse, who will notify one of these abuse coordinators immediately. The Administrator, Director of Nursing and/or Social Services Director will interview and/or examine the resident involved and initiate an investigation. When the alleged perpetrator is another resident of the facility, that resident shall be evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. Referral to the Social Work Consultant, Ombudsman or other appropriate personnel to assist in the evaluation or referral will be considered.

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide behavioral health services for 1 of 3 residents (R2) reviewed for behavior services in the sample of 6. This failure resulted in R1 being repeatedly yelled at, cursed at, and called names by R2.The findings include:The facility's policy and procedure revised 5/11/2019 showed, . Behavior Tracking/Management Program. Purpose: To provide a means to collect data regarding individual resident behaviors. This data will be used for the following reason: To collect a baseline to determine the extent of the problem(s); To Monitor the effectiveness of the plan of care developed; To monitor for behavior (including problems individuals have been placed on psychotropic medications for); To monitor for changes in behavior. FORMAT: Behavior monitoring will be individualized to the resident. At a minimum, the monitoring charting includes frequency of the behavior, interventions used, and effectiveness of interventions. METHOD: Behavior tracking will be evaluated, along with observation of the resident, and interviews with staff/family/ or other involved individuals This data will be incorporated into the comprehensive assessment. MONITORING: The Social Service Director and DON will monitor Behavior tracking for completion and accuracy. Periodic monitoring will also be done by the Social Service Consultant, and this will consist of review of the tracking and interviews of direct staff. PROCEDURE: 1) Behavior Management Team will meet on a regular basis to review residents' behaviors, diagnosis related to these behaviors, and interventions, both pharmaceutical and non-pharmaceutical. Each resident will be re-evaluated routinely and upon significant change in behavior. 2) Behavior Tracking will be kept for each resident in the residents' chart. SSD (Social Services Director compiles data and tracks for any pattern or change in behaviors. 3) Interdisciplinary Team will monitor for contributing factors with changes in behaviors such as but not limited to medical reasons. change in family situation, and environmental issues. The interdisciplinary team will also review if the approaches used are successful for resident or if other approaches may need to be discussed/attempted. 4) The Care Plan Team will review each resident every 90 days or upon significant change in condition. The Care Plan team will develop and revise as needed a plan of care for resident with behaviors with individualized interventions. R1's face sheet showed he was admitted to the facility 9/15/23 with diagnoses to include Parkinson's Disease without dyskinesia, hypertensive heart disease with failure, chronic congestive heart failure, peripheral vascular disease, and symptoms and signs involving cognitive functions and awareness. R1's 6/2/26 facility assessment showed he has moderate cognitive impairment and requires moderate assistance from staff for most of his cares.R1's care plan initiated 9/18/23 showed, [R1] has a diagnosis of Parkinson's Disease affecting his cognition. R1's care plan initiated 9/16/23 showed, [R1] has impaired cognitive function. 3/11/26 - Code Alert added to wheelchair (device to set off an alarm at the doors to alert staff if resident is trying to exit the facility). R1's care plan initiated 6/3/25 showed, . He has Parkinson's Disease, causing impaired cognition. [R1] has a female friend that he spends time with at the facility. [R1] has a special friend that he spends most of his time with. Both families are good with this arrangement.R2's face sheet showed she was admitted to the facility 3/3/23 with diagnoses to include polyarthritis, hypertension, dementia without behavior disturbance, muscle weakness, pain in right hip, pain in left knee, and depression. R2's facility assessment dated [DATE] showed she has moderate cognitive impairment and requires substantial to maximum assistance from staff for most cares. This same assessment showed R2 had no verbal behaviors directed toward others (e.g. threatening others, screaming at others, cursing at others). R2's care plan initiated 6/17/25 showed, . [R2] has a special male friend at [the facility] that she spends most of her time with. R2's care plan initiated 1/28/26 showed, [R2] at times will raise her voice at her male friend/peer. Diagnosis of Dementia. [R2] will decrease frequency of raising her voice at peer through the review date. When the resident becomes agitated: (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. [NAME] B/T (Behavior Tracking) if this resident is witnessed raising her voice/yelling at peer(s)/her male peer/friend. There have been no changes to the interventions on this care plan since it was initiated 1/18/26. R2's 9/21/25 Behavior Note entered at 7:30 PM showed, Resident resting in bed, her s.o. (significant other) [R1] is also a resident present in the room visiting. [R2] ordering hm to perform small tasks in room, very demanding and talking down to significant other. CNA (Certified Nursing Assistant) heard from hallway [R2] tell him [R1] that he was F*cking stupid and attempted to de-escalate situation and separate couple. [R2] then started yelling at CNA telling her that [R1] was not ready to leave. CNA politely informed resident that she was talking to significant other [R1] and asked him again if he wanted to get ready for bed. [R1] declined, CNA reported situation to this nurse. 7:45 PM This nurse then entered room, [R1] still doing small tasks. [R2] had decreased negative verbalizations in the presence of nurse. This nurse asked [R1] if he was doing O.K. or if he would like to get ready for bed. He stated he would but just wanted to finish last shore and would only be 5-10 more minutes. [R2] agreed to him leaving then. R1's 11/7/25 Behavior Note entered at 9:27 AM showed, Resident and other resident [R2] have been found multiple times in each other's rooms, screaming profanities and yelling at one another using abusive language. Even after redirection, the two continue to argue and cause a scene. Other residents and visitors near can hear this language and behavior and have shown concern. This nurse will speak with the social worker to discuss a plan of action regarding behaviors.R2's 1/8/26 Behavior Note entered by DON (Director of Nursing) at 12:57 PM showed, This nurse was at the nurse's station when she heard loud shouting. I got up to check on resident and find the source of yelling. As I got closer to her room, I could hear this resident yelling ?Behind you! By your elbow! Don't you know where your elbow is?', this nurse entered room of resident and noticed her male companion was also in the room, sitting in her recliner. This nurse asked, ?[R2], is there something you need help with? I can hear you yelling at [R1] from the desk.R2's 1/24/26 Behavior Note entered at 4:48 PM showed, Resident in room and staff at nurse's desk, was able to hear resident yelling and crying. Peer resident in room at the time. Staff heard peer resident tell [R2], ?I can't help you with that.' Resident then cried out loudly ?Just do it.'. Staff entered room and separated the 2 residents. Resident wanted to be boosted back in wheelchair. R1's 1/24/26 Behavior Note entered at 4:54 PM showed, Resident was in a peer resident room. Yelling was heard coming out of the room. Peer resident was yelling at this resident to perform a task that he is unable to do. Resident was heard telling peer resident ?I can't help you with that. This resident was assisted out of peer resident room to his own room. Resident told CNA (Certified Nursing Assistant) He can't drive that thing. He was able to drive it yesterday and today he can't.' CNA told resident that peer resident was a woman and resident agreed and then continued to refer to peer resident as a ?he'.R2's 5/13/26 Behavior Note entered at 3:20 PM by V2 DON showed, Resident noted yelling several times at male friend throughout shift. This nurse intervened and assisted resident with her requests when possible, however, sometimes her requests were unclear. Both this resident and male friend encouraged to use call light to ask staff for assistance with tasks. R2's 5/14/26 Behavior Note entered at 2:48 PM showed, While this nurse was receiving AM (morning) report at approximately 6:10 AM, this nurse and other staff could hear resident yelling at another resident, that she is in a relationship with. Resident was verbally yelling insults at the other resident, as he did not understand what she was asking of him. This nurse went into resident's room and separated the two. Later in the morning, resident was being pushed down the hallway by the resident she is in a relationship with. This nurse could hear resident cussing at him about her feet not being on her foot pedals the right way. As the other resident was trying to assist resident with her foot placement, resident yelled at him, ?You shit for brains! Not like that!' This nurse immediately intervened and separated the two for a second time, asking the male resident to go ahead to his room and this nurse would assist resident in what she needed. This nurse explained to resident that this nurse would be letting social services (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	know about this behavior, as it had been on going on at this point for nearly half the shift, and is not fair to the other resident. Resident looked at this nurse and yelled, ?The shit you are!' This nurse did report verbal abuse issues to. [V3 Social Services Director]. Later in the shift, this nurse again had to intervene and separate these residents, as resident again began to verbally assault her boyfriend with cuss words and derogatory statements.R2's 6/7/26 Behavior Note entered at 3:03 PM, Resident was in her room with another male, resident, and was overheard by staff, yelling at him. This nurse approached resident's room and inquired of the happenings. Resident states, ?Oh go away, he's just too dumb to understand what I am asking him to do.' This nurse observed male resident holding out a rag to resident, and he states, ?Here, this is what you asked for.' Before this nurse could intervene, resident yelled, ?I asked you for a rag! What are you blind?!' This nurse informed resident that the male resident, indeed had and was holding out to her, the rag that she had asked him to get for her. Resident became upset and started to cuss at this nurse and the male resident. This nurse promptly removed the male resident from resident's room and placed him into his own room. Later in the afternoon, this nurse was walking by resident's room and overheard her yelling, ?You're too stupid to understand!' This nurse entered resident's room and observed the male resident holding out a book to resident. This nurse inquired of the issue. Resident states, I asked him for that book, and he can't understand anything!' The male resident states, ?You told me a book, this is the one I found.' This nurse explained to the resident that what she was doing is verbal abuse, and it is not acceptable to treat another person this way, especially when they are trying to help. Resident states, ?The shit it is!' This nurse informed the male resident that it was time to leave the situation. The male resident agreed to allow this nurse to push him in his wheelchair back to his own room. When this nurse attempted to assist the male resident, resident put her feet straight out in front of the male resident's wheelchair and began to kick her feet up and down, in an attempt to keep the male resident from leaving. This nurse asked resident to please not put herself or the male resident at risk for injury, and resident stopped this behavior.R2's Behavior Tracking completed by the CNAs for March 2026 showed, [NAME] B/T (Behavior Tracking) if this resident is witnessed raising her voice/yelling at peer(s)/her male peer/friend. This behavior was documented as R2 having 85 documented instances of yelling at R1 in the month of March 2026. R2's April 2026 behavior tracking showed this behavior was documented as occurring 92 times. R2's May 2026 behavior tracking showed this behavior was documented as occurring 28 times. R2's June 2026 behavior tracking showed as of June 8th, this behavior was documented as occurring 12 times. All documented behaviors showed the intervention, sit and talk with him/her was completed. All except one documented behavior on June 7, 2026, showed this intervention was not effective. R1 and R2's rooms were located directly across the hall from each other. On 6/9/26 at 10:32 AM, V7 CNA (Certified Nursing Assistant) said, [R1] and [R2] have been in a relationship for a couple years. They do not get along, they argue quite a bit. She gets frustrated because she wants him to do everything for her. This happens every day. I think it is abusive. I think they should probably be moved so they aren't so close to each other. We report it but administration knows, they have seen it.On 6/9/26 at 11:13 AM, V4 LPN said, It is known throughout the facility that they are companions. On and off, she is very verbally aggressive and abusive to him. I have separated them multiple times, in fact this weekend I had to separate them again . I know they both have failing cognitive faculties. For instance, the last two times I witnessed verbal abuse from [R2], [R1] was trying to help her, and he was doing word for word what she was asking him to do. She was just insulting his intelligence. She was asking him a couple weeks ago to do something, and she called him ?shit for brains'. so I went and separated them. Then this weekend, the same scenario happened but they were in her room. She was asking him for a rag and when I was in there, he was handing her the rag, and she was yelling at him. I told her that he was handing her the rag. I said, ?[R2] apparently you are having a bad day, but I'm not letting [R1] sit here and take this. He doesn't deserve this.' Then later in the day, right before church, I heard a commotion, and she was yelling at him again. He was holding a book out to her, and she was just verbally insulting him all over again. I (continued on next page)

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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 0740 Level of Harm - Actual harm Residents Affected - Few	said, ?[R1], I'm so sorry, you are very tolerant, but I'm separating you again and I want you to stay apart until at least church.' V4 said when she went to remove R1 from R2's room, R2 put her feet up straight out and started kicking her feet to try and keep her from removing R1. V4 said she told R2 that it was dangerous to keep kicking her feet like that and could hurt R1 or herself doing this. V4 said they are reporting a lot of verbal aggression from R2 towards R1 to Social Services. V4 said she requested to have R1's room moved to provide some separation between R1 and R2. V4 said there was a room open not too long ago in the same hall, but further down. V4 said that way R1 and R3 wouldn't be right next to each other. V4 said she has gone to V3 (Social Services Director) at least 3 times suggesting room changes. V4 said V3 told her when they do R1 and R2's care plan meeting they talk about things and that some of these things were being addressed but V4 said it continues to happen. V4 said she has not reported anything to V1 (Administrator) because V3 (Social Services Director) is on the Abuse Committee. V4 said she feels Administration is 100% aware of this situation between R1 and R2. V4 said, This has been going on for months and months. every episode is not documented as often has happened, because it happens so frequently that most of our days would be spent documenting [R2's] behavior. God bless that man (R1), he is the most tolerant man and there was one day last week I think it was that he finally bit back and told her to stop yelling at him and use her damn eyes. I separated him from [R2] at that point, even though it is usually me separating [R2] from him. Her behavior is abusive. She is constantly taking shots at his intelligence. She cusses at him. When he is raising his voice back at her, that is when I can tell that it's affecting him, otherwise, he just has a flat affect and sits there. This can be heard through the halls. It is very loud. It goes on during mealtimes too now. When I report it, I'm told to keep documenting it because they go over these things in their care plans. [V3] told me that all I can do is document it. On 6/9/26 at 12:50 PM, V3 Social Services Director said, [V1 Administrator] and myself are the abuse coordinators. [R1] and [R2] both came in at separate times, but they made a connection a couple years ago. I don't know how they define the relationship, but we would see them as a couple or two very, very close friends. They are together throughout the day at meals, activities, events, that sort of thing. How they get along fluctuates. There are some tensions like any relationship. There are arguments between the two of them, but generally speaking, they have a very respectful relationship. I would say they both have low cognition. Behaviors have been reported to me, from time to time there is tension or stress, and they tend to separate or staff separate them as well. I saw the behavior notes today. I never heard or witnessed that verbal aspect as far as firsthand or being there in the moment. She does get frustrated, just in general and gets frustrated with him as well. Staff report general stress in the moment. If she is trying to say something and he isn't quite getting it, they intervene and try to help and fix what he needs and that fixes it in the moment. If she is cursing at him or saying derogatory things, that wouldn't be a good thing. (Reviewed Behavior Notes with V3) These particular details were not shared with me. These would require a 1:1 conversation.I would say they should separate the individuals and reduce or alleviate the stress in that particular moment. When things have been shared with me about [R1] and [R2], staff have already intervened. That is something we do on going, intervene. To prevent this from happening, we are trying to meet the needs of the individuals of course, being aware of where individuals are at, and if they are in a certain situation that is stressful maybe we are stopping and keeping an eye on things, it depends on the moment and the situation. We do behavior tracking. Social Services generally are putting the behavior tracking into the computer. we have our monthly psychotropic medication meeting and we review behavior tracking, medication dosages, and changes. During the meeting if we see behaviors documented, we discuss it from a medication standpoint and review to see if there are any interventions from a behavior standpoint. We discuss environmental changes, such as rearranging the room, changing get up times, or room changes. We don't document those meetings, we have them once a week, so we review everyone on a monthly basis and as needed of course. I don't recall any environmental changes being discussed for [R1] and [R2]. I don't know how often these behaviors are occurring, I would have to go back and (continued on next page)

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	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resthave Home-Whiteside County	408 Maple Avenue Morrison, IL 61270

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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 0740 Level of Harm - Actual harm Residents Affected - Few	look at the tracking. During the meeting we don't look at the nursing notes, we look at the medications. There are 3 core people in that meeting, [V1], [V21], and myself.On 6/9/26 at 2:35 PM, V2 DON (Director of Nursing) said, I'm part of the behavior committee. We break it into three parts, so everyone is done quarterly. We go through their medications and behaviors together. We talk about gradual dose reductions during that time and discuss any sort of behaviors that people are having. Even if they aren't in the group that we are discussing, that doesn't mean we can't bring it up with something that is happening that is disruptive. At times we talk about interventions, what is the cause of the behavior, what is the root cause, and what can we do to make sure that whatever the behavior is, isn't a safety risk. We are also talking about what we tried, what could we do additionally, how severe is the behavior, and if it warrants intervention. Any new interventions would be added by the Care Plan nurse. [R1] doesn't really have any behaviors, he is pleasantly confused. [R1] and [R2] bicker, she yells and wants things done for her. He wants to just serve her. I have gone in to find out what she needs, and I'll help her. It is always such piddly tasks, like picking something up off the floor. I don't think [R1] understands what she is asking him to do, sometimes I don't understand what she is asking for either. So, I think a little of her confusion comes in there too. It happens in the room most of the time. So far what we have talked about for them is that if we hear the arguments going on, go in and do whatever it is she needs, and check to see if [R1] is okay. I have taken him out of the room, but he will go right back in. If it is name calling or cursing at him, that would be abusive. (V2 reviewed R2's 6/7/26 Behavior Note) This nurse should have reported this, I read it the other day during morning meeting, and I wanted to talk to this nurse. She should have contacted the abuse coordinator. (V2 reviewed R2's 5/14/26 Behavior Note) There should have been an abuse investigation started on 5/14/26 from this note. I don't remember if I saw the 5/14/26 note. (V2 reviewed the 5/13/26 Behavior note that she entered in R2's chart) I don't consider her yelling at him to be verbal abuse, I took it as ?frustrated'. That day, she did not call him any names. It was on 5/13/26 that I first told [V3] about their bickering. I told [V3] I was down there and that we should probably move [R1]. I think it has been an issue for awhile but when I entered my last note 5/13/26, I told [V3] the poor man (R1) doesn't understand what she is asking. [V3] asked me if I had any ideas and I told him ?out of sight, out of mind'. [R2] calls for him so I think if we move him and leave her there and start having them eat in separate dining rooms, I think they would fine. At that time, he said okay and that we can talk to the family about it. They haven't been moved. Reviewing the behavior tracking, it appears concerning. Room changes were never discussed in our meeting.On 6/9/26 at 3:15 PM, V1 Administrator said, . There has been some aggravation between the two of them (R1 and R2) and as both of their dementia and cognitive deficits have gotten worse, the behaviors are getting worse. It would be something down the line we could do, is to move one of them if the behaviors have continued. The aggravation seems to be getting worse, and we may have to consider moving them to different sides of the building. Right now, they are right across the hall from each other. For the most part, their relationship has been very positive. It has been just recently that the aggravation has gotten worse. (V1 reviewed R2's Behavior Tracking documentation and Behavior Notes.) It is concerning for him (R1) to be yelled at like this. The Behavior Meetings do not include enough detail. The Social Workers run these meetings. They should be reviewing behaviors and reporting them. I would expect these behaviors to be identified, investigated, and the resident should be protected.