

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000325		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/10/2025	
NAME OF PROVIDER OR SUPPLIER THE HAVEN OF BEMENT.				STREET ADDRESS, CITY, STATE, ZIP CODE 601 NORTH MORGAN , BEMENT, Illinois, 61813			
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S0000	Initial Comments			S0000			10/30/2025
	Investigation of Facility Reported Incident of 9/22/25/2637680						
S9999	Final Observations			S9999			10/30/2025
	Statement of Licensure Violations:						
	300.610a)						
	300.1210a)						
	300.1210b)						
	300.1210d)6)						
	Section 300.610 Resident Care Policies						
	a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.						
	Section 300.1210 General Requirements for Nursing and Personal Care						
	a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to maintain transport equipment in working order and failed to safely secure one resident (R1) by not applying a seatbelt properly during resident transport. R1 experienced pain and obtained two nasal fractures and six sutures after falling while being transported in the facility van. The facility failed to implement fall interventions and failed to determine root causes for four falls for one (R3) resident. These failures affected two (R1, R3) residents out of three residents reviewed for Accidents in a sample list of three residents. Findings include: 1. R1's Electronic Medical Record (EMR) documents R1's medical diagnoses as athetoid cerebral palsy, anemia, glaucoma, primary osteoarthritis, difficulty walking, acute-on-chronic heart failure, adjustment disorder with anxiety, bilateral astigmatism, bilateral myopia, bilateral presbyopia, restless-leg syndrome, and a history of myocardial infarction. R1's Minimum Data Set (MDS), dated 9/23/25, documents that R1 is cognitively intact. The same MDS notes that R1 is dependent on staff for transfers and transportation.			S9999			

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S9999	Continued from page 2 R1's Care Plan intervention, dated 7/5/2024, directs staff to assist R1 in transferring to a wheelchair and to assist R1 in positioning for comfort during transfers and while up. It also instructs staff to help R1 achieve and maintain an upright posture and proper alignment, as possible, when out of bed. R1's Fall Risk Assessment, dated 6/23/25, classifies R1 as a high fall risk. R1's Physician Order Sheet (POS), dated October 2025, shows a physician's order, effective from 9/24/24 with no end date, to administer daily aspirin 81 /mg (milligram). R1's Hospital Record, dated 9/22/25, indicates R1 was evaluated in the emergency room following a fall from his wheelchair while in the facility's transport van. The record reports that R1 sustained:A 4.0 /cm /(centimeter)× /4.0 /cm forehead hematoma with mild bogginessA 1.0 /cm linear partial-thickness laceration to the extraoral upper lipA moderate abrasion to the nasal dorsumA 0.5 /cm linear full-thickness laceration to the right narisA 1.5 /cm linear laceration to the upper labial mucosalt further notes that R1 received suture repair on three lacerations under local anesthesia, and a pressure dressing was applied to the forehead hematoma. R1's CT scan of the maxillofacial region, dated 9/22/25, reveals a scalp hematoma involving the forehead and extending to the bridge of the nose and right medial canthus region, along with comminuted bilateral nasal bone fractures with slight displacement. R1's Fall Investigation, dated 9/22/25, documents that R1 had an unwitnessed fall in the facility van en route to a physician appointment. The investigation notes that R1 sustained: an abrasion to the top of the scalp; abrasion to the right elbow; an abrasion to the front of the right knee; an abrasion to the front of the left knee; facial bruising; a facial fracture; a nasal laceration; a skin tear to the back of the right hand; and a skin tear to the right forearm. R1's Nurse Progress Notes read:9/22/25, 6:31 /PM: R1 left the facility at approximately 7:30 /AM for a cardiology appointment and returned at 3:45 /PM. The note states R1 fell during transport and was taken by ambulance to the emergency room. Upon return, R1 complained of a headache. The skin assessment found dime-size abrasions under the right knee, left knee,			S9999			

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S9999	Continued from page 3 and right elbow; a skin tear to the right lower arm (unapproximated due to dried blood and skin); a dime-size abrasion on the top of the head; and bruising to both eyes and the nose. The note also reports six stitches on the right side/under the right side of the nose, with swelling to the right side of the face and eyes. It states:"(R1's) elastic wrap is in place to forehead and, per hospital instructions, should not be removed for 24 hours due to swelling/hematoma of the forehead. Unable to assess the skin under the wrap. Swelling noted to right wrist/arm. (R1) states he was sitting up in his wheelchair in the transport van when, suddenly, he fell out, landing on his right side."9/22/25, 6:53 /PM: R1 was seen in the emergency room and diagnosed with traumatic hematoma of the forehead, facial laceration, fall from wheelchair, cervical stenosis of the spinal canal, and closed nasal bone fractures.9/23/25, 11:59 /AM: R1 declined a shower, stating his body was too sore from the fall on 9/22/25.R1's Provider Progress Note, dated 9/23/25 at 12:21 /PM, states: "(R1) is seen post fall/E.R. visit for broken nose. (R1) fell and hit his face due to van malfunction. (R1) has a mild headache and is using acetaminophen. (R1) has bruising on his face." The invoice report dated 9/26/25 for maintenance of the facility's transport van documents that the van lift inspection revealed: "Missing some odds-and-ends hardware; adjusted handrail tension at stow; adjusted stow blocks; adjusted towers one and two; cleaned out floor tracks and locks on retractors." R1's final report to the State Agency, dated 9/29/25, states that R1 fell out of his wheelchair while being transported to a physician appointment on 9/22/25. The report notes that R1 was sent to the emergency room after the fall, which caused a laceration requiring six sutures to the right side of his nose and closed nasal fractures. It further documents that V3 Maintenance Director inspected the van and replaced a safety belt; an outside vendor also inspected and replaced hardware. The facility determined the fall was caused by a faulty seat belt attachment. Staff were re-educated on van mechanics and resident transportation procedures. On 10/9/25 at 1:30 /PM, V1 Administrator, V2 Director of Nurses (DON), V3 Maintenance Director, V4 Transport Aide, V5 CNA (Certified Nurses Assistant), and V6 Regional Clinical Nurse reenacted the fall. V5 sat in a wheelchair in the van while V4 fastened the belts. Both		S9999				

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S9999	Continued from page 4 rear belts were stiff and loose. V4 stated this method was unsafe. V1 confirmed the straps were too loose and could detach easily. V3 replaced a retractable anchor and remarked: "Once the material has that much age on it, it tends to stiffen up. This lap belt is not safe because there is no give in it. It needs replacement." On 10/10/25 at 9:00 /AM, R1 was lying in bed with dark black/gray areas under both eyes and yellow circles around the eyes. On 10/9/25 at 11:20 /AM, V4 stated she assisted R1 into the van on 9/22/25, placed lap belts over his wheelchair, and attached them to floor anchors—but did not realize one anchor was loose and did not test it. Turning into the physician's parking lot, she heard a "thud," looked back, and saw that R1 had been flung from the wheelchair onto the van floor. After emergency transport, V4 rechecked the van and found the back-right wheelchair anchor was unattached. Because R1's lap belt was not secured properly and the anchor was disconnected, R1 fell forward out of his wheelchair, injuring himself. On 10/10/25 at 10:10 /AM, V10 PTA (Physical Therapy Aide) said R1 had declined over the past two years and restarted physical therapy on 9/12/25 after another fall. V10 said R1 has a "healthy fear of falling" and is "very hesitant" with transfers, often reaching out due to his poor vision. On 10/10/25 at 12:30 /PM, R1 stated he was placed in the van for a physician appointment when the seatbelt detached from the floor anchor. He said he has been "nervous" about falling because he sees only "cloudy figures." He said he was "very scared" before the 9/22/25 fall and is now "terrified." He said he experienced fear and pain as a result of falling in the van. R1 said V4 buckled him in but should have verified the seatbelt's functionality prior to transport. 2. R3's EMR lists medical diagnoses including cerebral infarction, vascular dementia, persistent mood disorder, reduced mobility, mild neurocognitive disorder, hearing loss, difficulty walking, muscle wasting and atrophy, gait and mobility abnormalities, muscle weakness, macular degeneration, urinary incontinence, and a cognitive-communication deficit. R3's MDS dated 9/5/25 documents R3 as moderately cognitively impaired, requiring maximum staff assistance for bed mobility and dependency for oral		S9999				

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S9999	Continued from page 5 hygiene, toileting, bathing, dressing, personal hygiene, and transfers. R3's Care Plan intervention dated 6/13/2020 mandates use of a total-body mechanical lift with two staff for all transfers. A fall intervention added 8/23/24 directs lowering R3's wheelchair seat; another intervention added 8/28/24 requires an alarm in his wheelchair. No fall intervention was added following the 9/23/25 fall. R3's Fall Risk Assessment dated 6/6/25 classifies R3 as high fall risk. R3's Nurse Progress Notes:7/2/25 at 4:54 /AM: R3 was found sitting on the floor beside his bed. He stated he had attempted a self-transfer.7/4/25: The notes lack documentation about a fall at 9:29 /PM.8/8/25 at 5:18 /AM: R3 was found beside his bed on the floor and said he tried to self-transfer.9/23/25: Notes omit details of a fall at 1:40 /AM.R3's Fall Investigations:7/2/25: An unwitnessed fall at 4:30 /AM occurred when R3 was trying to get up and was incontinent. The investigation does not include a root cause analysis.7/4/25: An unwitnessed fall at 9:29 /PM found R3 lying next to his bed and incontinent. No root cause is provided.8/8/25: An unwitnessed fall at 4:15 /AM left R3 on the floor beside his bed; he said he attempted to self-transfer. No root cause is documented.9/23/25: An unwitnessed fall at 1:40 /AM found R3 on the floor beside his bed and incontinent. The investigation notes that R1 was unable to describe the fall. No root cause is identified.On 10/10/25 at 9:35 /AM, V11 CNA transferred R3 from his bed to his wheelchair without additional staff, without a mechanical lift, and without a gait belt. At 9:40 /AM, R3 was in his wheelchair in the dining room drinking hot coffee. No staff were present. His wheelchair seat was not lowered, and no personal alarms were installed. At 10:00 /AM, V11 CNA admitted she transferred R3 without help, without the lift, and without a gait belt. She said she knew two staff and a mechanical lift were required but sometimes does not follow that. She said staff practices vary—sometimes using the lift, sometimes physically transferring R3. At 10:15 /AM, V7, Director of Rehabilitation Services, assessed R3's wheelchair. She observed the seat was in its highest position, though it could be lowered. She said wheelchair adjustments are normally reviewed with therapy. She was unaware that R3's Care Plan includes			S9999			

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S9999	Continued from page 6 lowering the seat. At 11:25 /AM, V1 Administrator stated that R3's fall interventions did not align with his falls on 7/2/25, 7/4/25, 8/8/25, and 9/23/25, particularly because no root causes were documented. The Administrator said that when a resident falls, the interdisciplinary team (IDT) should discuss the fall, implement an appropriate intervention plan, and educate staff. She said merely documenting what happened is insufficient to identify a root cause. She commented: "Just because (R3) tries to get up on his own does not tell us why he is attempting to get up. The root cause might be incontinence, hunger, pain, etcetera." She concluded that the root causes of R3's falls were never determined. The facility policy titled Falls Guideline, revised August 2024, defines a fall as any failure to maintain appropriate lying, sitting, or standing position that results in unintentional relocation to the ground or another object lower than the starting point. It mandates that all residents at fall risk be reviewed for individualized interventions. Fall management should include review of physical devices, hazard analysis, cause identification, intervention development and implementation, and ongoing evaluation. Staff must evaluate and document all falls—including when and where they occurred and observational details. Documentation should contain sufficient information to help determine the cause of the fall. (B)			S9999			