

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 01/21/2026	
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 Complaint Investigations: 2660528/2715406 25612490/2697193 Facility Reported Incident of 11/7/2025/2678176		S0000			02/09/2026	
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1210b) 300.1210d)3) 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 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		S9999			02/09/2026	

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 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements were not met as evidenced by: Based on interview and record review the facility failed to accurately assess a resident for weight loss for one (R1) of three residents reviewed for nutrition. A significant weight loss was not identified, and interventions were not put in place to prevent further weight loss resulting in R1 being admitted to the hospital with a diagnosis of Hypokalemia due to malnutrition/dehydration. Findings include: The facility policy Lab, Diagnostic Test Results and Change in Resident's Condition - Clinical Protocol Dated November 2016 documents to establish guidelines for physician notifications concerning resident lab and diagnostic tests results and change(s) in resident conditions. The policy further documents 2. The person who is to communicate results to a physician will review, compile the information and be prepared to discuss the following: a. the individual's current condition and any recent changes in status, including vital signs and mental status. The facility's undated policy Nutrition (Impaired)/Unplanned Weight Loss – Clinical Protocol documents 1. Monitor and document the weight and nutritional status of residents in a format which permits readily available month-to-month comparisons. 2. Assess the individual's current nutritional status and identify individuals with anorexia, recent weight loss, and significant risk for subsequently impaired nutrition. 4. The staff will notify family of significant weight gains or losses or any abrupt or persistent decline from baseline appetite or food intake. The policy further documents 1. The physician and/or designee will review possible causes of anorexia or weight loss with the nursing staff and/or dietitian		S9999				

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S9999	Continued from page 2 before ordering interventions. a. For individuals with recent or rapid weight loss (for example, more than a pound a day), the staff and physician should consider possible fluid and electrolyte imbalance as a cause. Monitoring: I. The physician and staff will monitor the nutritional status, response to interventions, and possible complications of such interventions (for example, aspiration, diarrhea, nausea, or vomiting) of individuals with impaired nutritional status. On 01/15/26 at 11:30am, R1's care plan documented an admission date of 11/25/2025 with diagnosis of Diabetes Mellitus Due to Underlying Condition with Diabetic Neuropathy, Unspecified (E08.40), and Other Lack of Coordination (R27.8). On 01/15/26 at 11:35am, R1's medical record review documents the following weights were obtained during R1's stay at the facility: Admission weight: 11/25/2025 6:17pm 175.2 pounds (lbs.) Wheelchair. 11/26/2025 1:25pm 170.4 lbs. Mechanical Lift (Full Body), -4.8lbs (-3%) 11/27/2025 11:20am 157.1 lbs. Mechanical Lift (Full Body), -13.3lbs (-8%) 12/5/2025 11:54am 163.6 lbs. Mechanical Lift (Full Body), +6.5lbs (+4%) 12/9/2025 12:41pm 164.8 lbs. Mechanical Lift (Full Body), +1.2lbs (+.7%) 12/11/2025 1:48pm 164.2 lbs. Wheelchair, -.6 lbs. (-.5%) 12/16/2025 9:57am 161.1 Lbs -3.1lbs (-2%) Total weight loss from admission date of 11/25/2025 to date of discharge 12/16/2025 (22 Days) -14.1 lbs or -8%. On 01/20/26 at 10:37am, R1's medical record review documents during R1's stay at the facility R1 was served 61 meals. Of those 61 meals, six of them did not document a percentage of consumption. Twenty-nine of the 55 meals documented noted less than 50% of the meal consumed. Fifteen of the 55 meals documented less than 25% consumed. On 01/15/26 at 11:35am, R1's medical record review documents on 12/16/2025 a nurse practitioner called			S9999			

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S9999	Continued from page 3 Emergency Medical Services (EMS) to take R1 to the hospital due to R1 was exhibiting signs and symptoms of a stroke. On 01/15/26 at 11:35am, R1's hospital record review documents on 12/16/2025 R1 was admitted to the local hospital with a potassium level of 2.0 (Panic level low) on a scale of 3.5-5.1 mmol/L (millimoles per liter). The hospital discharge paperwork dated 11/25/2025 documents R1 having a potassium level of 4.0 on a scale of 3.5-5.1 mmol/L. On 01/15/26 at 11:35am, R1's medical record review documents on 12/2/25 R1 had labs done while at the facility and document a potassium level of 3.5 on a scale of 3.5-5.3 mEq/L (milliequivalents per liter). Labs drawn on 12/16/25 prior to discharge from the facility document potassium 2.6 on a scale 3.5-5.3 mEq/L. Demonstrating an electrolyte imbalance/ downward trend while at the facility. On 01/15/26 at 11:35am, R1's medical record review documents on 12/11/2025 V9 License Practical Nurse (LPN), documented V23 Speech Therapist informed V9 that V23 had to assist the resident with eating lunch. V23 stated R1 seems to be declining. On 01/15/26 at 10:23am, V9 LPN stated the note in the medical record was written by V9. V9 stated V9 could not recall notifying the family or physician of a decline in health of R1. V9 stated V9 did not inform the physician or family of R1's weight loss. On 01/15/26 at 10:56am, V12 Registered Nurse/Nurse Practitioner (NP) confirmed V12 was not informed of the weight loss R1 was experiencing. V12 confirmed limited consumption of meals would lead to weight loss and electrolyte imbalance. On 01/15/26 at 12:48pm, V14 Registered Dietician (RD) confirmed V14 was not informed of the weight loss by R1. V14 stated V14 would have asked for a re-weight of R1 to confirm the weight loss and then made recommendations based on clinical evidence of the weight loss. V14 confirmed V14 did not see R1 in the nursing home and made the diet recommendation from previous speech therapy notes from R1's medical records. On 01/15/26 at 12:48pm V15, Primary Care Physician, confirmed V15 was not notified of the weight loss by R1. V15 confirmed if R1 was consuming less than 50% of meals it would lead to weight loss and electrolyte imbalance. V15 stated V15 would have ordered labs and	S9999					

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S9999	Continued from page 4 recommendations/orders based on R1 abilities and preferences. On 01/20/26 at 10:29am V25, R1 family, confirmed V25 was not informed of R1's weight loss or lack of food consumption. On 01/21/26 at 09:18am, V23 Speech Therapist confirmed V23 noted a sharp decline in R1's abilities including talking less and not feeding herself. V23 stated on 12/11/25 V23 informed V9 that R1 was experiencing a decline in overall health and was requiring more assistance to complete tasks. On 01/21/26 at 12:48pm, V2 Director of Nursing (DON) confirmed R1 had a significant weight loss, and that family/Physician/Registered Dietician had not been notified of the weight loss. V2 confirmed R1 was sent to the local hospital on 12/16/25 for altered mental status, possible stroke. On 01/22/2026 at 12:24pm, V24 Hospitalist/Doctor, confirmed on 12/16/25 R1 was admitted to the hospital with the admitting diagnosis of Hypokalemia (low potassium) (electrolyte imbalance) secondary to severe malnutrition/dehydration. V24 stated R1 had to have multiple intravenous potassium injections to get the potassium back to normal range. V24 stated the lack of food and drink at the facility was the cause of the Hypokalemia. (A) 2 of 2 300.610a) 300.1210b) 300.3210t) 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.			S9999			

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S9999	Continued from page 5 Section 300.1210 General Requirements for Nursing and Personal Care 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. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidenced by: Based on Interview and record review the facility failed to replace misappropriated goods in a reasonable time frame for one (R3) of three residents reviewed for misappropriation. R3 was upset and angered of having to replace (ear buds) with R3's own personal money and the facility not reporting this to the police as R3 wanted to press charges. This failure to report to the police and to replace the goods in a timely fashion resulted in psychosocial harm to R3. Findings Include: The Facilities Abuse Prevention Policy Dated 1/25 documents that the facility affirms the right of the resident to be free from misappropriation of property, deprivation of goods and services by staff or mistreatment. This policy also documents that the facility would keep the resident informed of the conclusions of the investigations. On 11/6/2026 at 9:30PM, R3 reported that R3's (ear buds) were missing from R3's room and the facility reported this to the state agency. On 11/14/2025 the final report was provided to the state agency which documents that on 11/6/2025 R3 went to put on R3's (ear buds) that R3 kept in a specific place when R3 realized they were not there. R3 utilized the (tracking) function on R3's cellular phone and the missing (ear buds) were pinged (located) at an address (about 30 miles away). R3 asked the Certified Nursing Assistant on shift what her address was which the Certified Nursing Assistant stated she lives with her mom who is also a Certified Nursing Assistant at the facility and		S9999				

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S9999	Continued from page 6 confirmed the address where the missing (ear buds) were located. The Facility Incident Documents that the Certified Nursing Assistance was terminated, (Local Police Department) notified, and the facility was replacing the (ear buds) for R3. On 1/13/2026 at 12:27PM, R3 stated R3's (ear buds) were missing after R3's room was deep cleaned on 11/6/2025. The Certified Nurse Assistant was helping R3 put all R3's personal belongings on R3's bedside table. R3 stated he noticed them missing when R3 went to put the (ear buds) in around 9:00PM on 11/6/2025. R3 stated that R3 used the (racking) function on R3's cellular phone which came up to an address of a mother and daughter who were employed as Certified Nursing Assistants at the facility. R3 stated R3 reported the theft to V1 but did not speak to a police officer that night. R3 stated R3 still would like to press charges but was told by V1 Administrator that no charges are being pressed. R3 stated that V1 stated they would get R3 new (ear buds), but R3 had already bought (ear buds) out of R3's own money but stated R3 would like reimbursement for the money spent on replacing the ear buds. R3 also stated V1 came into R3's room on 1/13/2026 and told R3 that the check was mailed and R3 will be getting a refund for \$249.54. R3 stated that it upsets and angers R3, as this is R3's home and that someone can just steal from R3 and other residents. R3 again stated he wants to press charges as it has been over two months since the incident. (B)			S9999			