

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 03/13/2026	
NAME OF PROVIDER OR SUPPLIER THE HAVEN OF BEMENT.				STREET ADDRESS, CITY, STATE, ZIP CODE 601 NORTH MORGAN , BEMENT, Illinois, 61813			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S0000	Initial Comments Annual Licensure Survey Complaint Investigation 26619742745705 Facility Reported Incident of 1/29/26/2740976			S0000			03/27/2026
S9999	Final Observations Statement of Licensure Violations: 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. 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			S9999			03/27/2026

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 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 observation, interview, and record review the facility failed to protect the residents' right to be free from verbal and physical abuse by another resident for two of four residents (R18, R23) reviewed for abuse on the sample list of 27. This failure resulted in R23 experiencing physical pain, distress, and fear after R44 hit R23 in the stomach on three separate occasions. 1. R23's Census Detail and Medical Diagnoses List dated 3/10/26 documents R23 was admitted to the facility 11/3/25 with medical diagnoses including Cerebral Vascular Accident with Physical Symptoms, Quadriplegia, Anxiety, and Contractures. R23's Minimum Data Set Assessment (MDS) dated 2/12/26 documents R23 is totally dependent on staff for all daily living activity including eating, oral hygiene, dressing, grooming, personal hygiene, bathing, mobility in a specialized wheelchair, and transfers between the bed and wheelchair. This MDS documents R23 is non-verbal and communicates with yes and no responses by nodding or shaking his head. This MDS documents R23 is cognitively intact with a brief interview rating of 15 out of a possible 15. R44's Census Detail and Medical Diagnoses List dated 3/10/26 documents R44 was admitted to the facility 7/22/25 with medical diagnoses including Personality Disorder, Bipolar Disorder, Schizoaffective Disorder, Major Recurrent Depression, Anxiety, Stimulant Abuse, and Cannabis Use. R44's MDS dated 1/28/26 documents R44 requires only supervision to accomplish all daily living activity, is ambulatory throughout the facility, uses tobacco, and makes attempts to leave the building without notifying staff. R44's Nursing Progress Note dated 1/30/26 documents, "On 1/30/26 (R44) was arrested for allegations of hitting his non-verbal roommate. The roommate indicated that (R44) had hit him in the stomach on 3 occasions due to (R44) not getting his way within the facility, (Smoking/Leaving)." R23's Nursing Progress Note dated 1/26/26 documents, "Was reported resident had decreased appetite		S9999				

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S9999	Continued from page 2 yesterday, fed by staff." R23's Nursing Progress Note dated 1/28/26 documents, "Resident had complained of upset stomach earlier this shift and had refused breakfast." R23's Nursing Progress Note dated 1/29/26 documents, "CNA (Certified Nursing Assistant, unidentified) brought resident for this writer to talk with him and to do assessment on him. Resident was afraid to return to his room r/t (related to) his roommate. After further evaluation it was found that resident made accusation that his roommate assaulted him. Resident moved to safe place in facility. Resident was assessed from head to toe for any marks or bruises on him. There were no bruises or any markings from resident of an apparent assault. Resident was able to communicate with yes or no questions to answers by shaking his head yes or no." R23's Nursing Progress Note dated 1/30/26 documents, "On 1/29/26 (R23) indicated his roommate hits him in the stomach. One hit each time with a closed fist and walks away. He doesn't say a word. This has happened three times in the last couple of weeks. (R23) indicated this seems to happen when his roommate is upset with something within the facility. (R23) and his roommate were immediately separated. (R23) was moved to the other hall of the facility, the cops (police) were called, the incident was investigated, and the roommate was removed from the facility in the custody of the (local) Police Department." R44 was not available for observations nor interview due to being a discharged resident. On 3/10/26 at 3:47 PM, R23 communicated with "yes" and "no" responses by movement of his head and eyes. R23 communicated he had experienced problems with his roommate (R44) who was punching him. R23 communicated it hurt and made him feel bad when R44 punched him. R23 communicated he was afraid of his roommate and the facility staff moved him (R23) to a different room. R23 confirmed R44 no longer resides in the facility. R23 was in bed watching a video device and besides his head movements, was only able to move his left arm approximately 4 inches. R23's Care Plan problem area dated 2/11/26 documents R23 is at risk of abuse: roommate was punching R23 in the stomach at night three times. R44's Involuntary Discharge Notice dated 1/30/26 documents R23 reported being in fear for his personal			S9999			

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S9999	Continued from page 3 safety and exhibited signs of fear and distress observed by facility staff. On 3/12/26 at 9:40 AM, V1, Administrator, stated R44 had been arrested and charged with felony aggravated assault due to R23 being handicapped. The facility's Final Investigative Report to the State Agency (undated) documents R23 had complained of a stomachache on 1/29/26 and that was when R23 communicated that his roommate had struck him. This report documents that R44 was arrested by local law enforcement and R44 would not be returning to the facility. The (local) Police Department Incident Report dated 1/30/36 documents V21, Police Officer, responded to the facility, interviewed V1 Administrator, V22 Registered Nurse, V10 Social Services Director, all of whom had interviewed R23, and then interviewed R23, all with his body camera recording. V21 documented R23 confirmed the allegations of R44 punching him on three separate occasions and had fear of reprisal from R44 for reporting the assault if R44 stayed as a resident in the facility. V21 went on to document he had a previous experience with R44 in 2025 when R44 walked out of this same facility and threatened to be violent with staff if they tried to stop him from leaving. V21 documented he followed R44 for 10 blocks in his squad car, while in full uniform, and finally was able to take R44 into custody, with assistance of a deputy, as R44 walked down the middle of a state route. The county courtroom documentation dated 3/12/26 confirms R44 was arraigned on charge of aggravated felony assault. 2. R18's Minimum Data Set (MDS) dated 1/9/26 documents R18 has moderate cognitive impairment. R18's current Diagnoses List documents "Major Depressive Disorder, Recurrent, In Full Remission." R15's MDS dated 01/16/26 documents R15 is cognitively intact. R15's Current Diagnoses List documents Dementia without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety. The Initial Report dated 3/10/26, documents "Yesterday (3/9/26), a (Private Company) staff member (V7,Psychotherapist/ Licensed Clinical Social Worker) brought to my (V1) attention that she heard (R15) call			S9999			

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S9999	Continued from page 4 (R18) a name. The residents were moved to separate rooms at that time. (R18) expressed concerns to a surveyor regarding her former roommate, (R15). (R18) described feeling fearful of (R15), citing an incident where (R15) called her derogatory names the previous week, which (R18) was too afraid to report at the time. (R18) also noted that (R15) regularly uses offensive language and adopts a confrontational tone in her interactions with others." On 3/10/26 at 2:15 pm V10, Social Service Director (SSD) stated V7, Psychotherapist/ Licensed Clinical Social Worker (LCSW) came to V10 and reported that R15 and R18 had a verbal altercation yesterday (3/9/26). V10 stated "I directed her to report to (V1, Administrator/Abuse Prevention Coordinator), and she did." On 3/10/26 at 3:20 pm V9, Certified Nursing Assistant (CNA) stated "We all heard it. It was (R15) yelling at (R18) at first. (R18) was pretty upset, and (R15) was loud. (R18 and R15) then began to bicker back and forth. I went into their room and de-escalated things. As I said, (R18) was pretty upset initially and (R15) was still trying to bicker with her (R18). Once everything calmed down, I went and told the Administrator and one of the other CNAs told the nurse." "This all happened about a week ago (prior to 3/09/26 witnessed verbal abuse allegation reported by V7 LCSW and V10, LCSW report). I reported it immediately after I calmed down the situation." On 03/10/2026 at 10:03 am R18 stated she had been R15's roommate and was moved to a separate room after R15 yelled, cussed, and used the f*** (expletive) word repeatedly. R18 stated she is afraid of R15 and did not want to give R15's name because she feels R15 would retaliate. R18 also stated this occurred about a week ago. R18 said "She (R15) scares me." On 3/10/26 at 2:20 pm V1, Administrator/ Abuse Prevention Coordinator stated "(V7, LCSW/Psychotherapist) was in the building doing rounds and reported that (R15) called (R18) a d*** a** (expletive). I thought of it as more of a grievance, though I did not write it on the grievance log. I recognize, it should have been handled as a potential abuse issue." The facility undated Abuse Prevention Policy documents the following: This facility affirms the right of our residents to be free from abuse, neglect, exploitation,	S9999					

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S9999	Continued from page 5 misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of property and mistreatment by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals. Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention (77 Ill. Adm. Code 300.330). Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment (42 CFR 483.12 Interpretive Guidelines). Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individual's age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never to be able to see his/her family again (42 CFR 483.12 Interpretive Guidelines). (B)		S9999				