

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ASL510293</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/13/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>RESTHAVE HOME OF WHITESIDE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>408 MAPLE AVE</b> <b>MORRISON, IL 61270</b>
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A 000	Initial Comment  Complaint investigation 2510267/ IL 184250, completed on 1/14/25 by LSC-Unsubstantiated Complaint investigation 2510240/ IL 184114-Unsubstantiated Facility Reported Incident of 9/4/25, IL 197386-Substantiated 295.2000a)5)6)e) 295.9000a)	A 000		
A2000	Section 295.2000 Residency Requirements  This Regulation is not met as evidenced by: General Violation  Section 295.2000 Residency Requirements  a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate aservices, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act) .  5) The person requires more than minimal assistance in moving to a safe area in an emergency. For the purpose of this Section, minimal assistance means that the resident is able to respond, with or without assistance, in an emergency to protect himself/herself, given the staffing and construction of the building; 6) The person has a severe mental illness, which for the purposes of this Section means a	A2000		

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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A2000	<p>Continued From page 1</p> <p>condition that is characterized by the presence of a major mental disorder as classified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), where the individual is substantially disabled due to mental illness in the areas of self-maintenance, social functioning, activities of community living and work skills, and the disability specified is expected to be present for a period of not less than one year, but does not mean Alzheimer's disease and other forms of dementia based on organic or physical disorders. Nothing in this Section is meant to prohibit an individual with a diagnosis of depression from living in an establishment so long as the resident is not substantially disabled in the areas of self-maintenance, social functioning, activities of community living, and work skills;</p> <p>e) Residency shall be terminated in accordance with Section 295.2010 of this Part when services available to the resident in the establishment are no longer adequate to meet the needs of the resident. This provision shall not be interpreted as limiting the authority of the Department to require the residency termination of individuals. (Section 75(e) of the Act) .</p> <p>These Requirements Were Not Met as Evidenced By:</p> <p>Based on observation, clinical record review , incident report review and staff interview, the facility failed to ensure that 1 admitted resident was appropriate for admission. This was found in 1 of 3 residents (R1), reviewed. This failure resulted in R1 elopement from the facility , falling and sustaining a knee scratch and 1 swollen finger.</p>	A2000		

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A2000	<p>Continued From page 2</p> <p>This failure has the probability to affect all residents in the facility.</p> <p>Findings Include:</p> <p>The clinical record of R1 was reviewed on 9/13/25 . R1 was admitted on 7/11/22 with diagnosis including: falls; dementia without behavior disturbance; mood or anxiety; generalized anxiety disorder and obesity. R1 current service plan includes : elopement risk; 15 minute checks; wander guard; independently ambulatory with 2 wheel walker.</p> <p>On 9/13/25, R1 was observed at the end of hallway-A near an exit door. R1 was ambulating independently with a walker . Wander Guard intact on R1's left wrist.</p> <p>Observation of the facility indicated all hallways had an exit door with alarm. Observed signage at all exit doors with the following," DOOR WILL ALARM WHEN OPENED WITH A 15 SECOND DELAYED LOCK."</p> <p>Usage of wander guards are not permitted in Illinois assisted living establishments.</p> <p>Incident report dated 9/4/25 at 12:49 AM stated," R1 was last seen at bed checks around midnight. R1 was sitting in recliner chair. Staff alerted to call pendant activation around 12:49 AM. When staff entered R1's room,R1 was missing. R1 exited from the C-hall door. R1 walked to the green dumpster located behind the facility. R1 proceeded to walk, fell down ( lost call pendant ) and sat on the curb. R1 was found sitting on the curb. by staff and local law enforcement officer. R1 sustained a knee scratch and 1 swollen finger "</p>	A2000		

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A2000	Continued From page 3  Interview with E2 ( Nurse Supervisor) on 9/13/25 stated," R1 is odd,and takes a long time to answer questions and gets fixed on things like bills. R1's doctor said R1 has always been that way. R1 is alert and oriented, but gets carried away and makes things up. R1 is not normally a wanderer, has a 2 wheel walker, steady on the feet and independent. R1 now has a wander guard. R1 was found in the parking lot . R1 said R1 was going out dancing."	A2000		
A9000	Section 295.9000 Physical Plant  This Regulation is not met as evidenced by: General Violation  Section 295.9000 Physical Plant a) The establishment shall comply with the residential board and care occupancies chapter of the National Fire Protection Association's (NFPA) Life Safety Code (Life Safety Code) 101, Chapter 32, New Residential Board and Care Occupancies.  This Requirement Was Not Met As Evidenced By:  Based on observation, clinical record review and incident report review, the facility failed to comply with the residential board and care occupancies chapter of the National Fire Protection Association's (NFPA) Life Safety Code (Life Safety Code) 101, Chapter 32, New Residential Board and Care Occupancies. This involves 1 of 3 residents reviewed (R1).	A9000		

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A9000	<p>Continued From page 4</p> <p>This failure has the probability to lock all residents in the facility after wander guard activation.</p> <p>Findings Include:</p> <p>The clinical record of R1 was reviewed on 9/13/25 . R1 was admitted on 7/11/22 with diagnosis including: falls; dementia without behavior disturbance; mood or anxiety; generalized anxiety disorder and obesity.behavior disturbance; mood or anxiety; generalized anxiety disorder and obesity.</p> <p>R1 current service plan includes : elopement risk; 15 minute checks; wander guard; independently ambulatory with 2 wheel walker.</p> <p>On 9/13/25, R1 was observed at the end of hallway-A near an exit door. R1 was ambulating independently with a walker . Wander Guard intact on R1's left wrist.</p> <p>Observation of the facility indicated all hallways had an exit door with alarm. Observed signage at all exit doors with the following," DOOR WILL ALARM WHEN OPENED WITH A 15 SECOND DELAYED LOCK."</p> <p>Usage of wander guards are not permitted in Illinois assisted living establishments.</p> <p>Incident report dated 9/4/25 at 12:49 AM stated," R1 was last seen at bed checks around midnight. R1 was sitting in recliner chair. Staff alerted to call pendant activation around 12:49 AM. When staff entered R1's room,R1 was missing. R1 exited from the C-hall door. R1 walked to the green dumpster located behind the facility. R1 proceeded to walk, fell down ( lost call pendant ) and sat on the curb. R1 was found sitting on the curb. by staff and local law enforcement officer.</p>	A9000		

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