STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145440	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neighbors Health Center	811 West 2nd Byron, IL 61010

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interview and record review the facility failed to assess a resident for return from an acute care hospitalization and failed to document specific resident needs that cannot be met by the facility upon a resident's proposed return from an acute care stay for 1 of 1 resident (R1) reviewed for involuntary discharge in the sample of 3. The findings include:R1's Nursing Notes on 3/31/26 show that around 5:00 PM, R1 was found in her room cutting her arm with a pair of cuticle scissors. R1 was sent to the hospital. On 4/8/26 at 12:49 PM, V1 (Administrator) said that she filled out an Involuntary Discharge (IVD) Form for R1 on 3/31/26 and it was delivered to the emergency room on 3/31/26. V1 said that it was provided because of the self-harm and she knew that she would require additional support services that the facility was unable to provide to her. V1 said that they haves a psychiatric Nurse Practitioner that comes to the facility every two weeks. V1 said that she received a call from the hospital on 4/2/26 that R1 was ready to be discharged back to the facility. V1 said that she asked the person if she was aware that R1 was issued an IVD. V1 said that the person then said that she has been cleared medically and by psychiatry to return to the facility. V1 said that she told the person that she was just reviewing the chart and it shows that R1 is still a 1:1, is at moderate suicidal risk and was just started on new medications that need monitoring. V1 said that the person then thanked her and said that they would be back in touch with them. V1 said that later that afternoon, she received a call from V12 (Hospital Psychiatric Nurse Practitioner) and V12 told her that the hospital records must be wrong because R1 has moved to low risk and is on every 15 minute checks. V1 said that V12 asked her if she was abandoning R1 at the hospital and she responded, absolutely not, we want her to get the treatment that she needs, you have all these protocols, how could I accept her back. V1 said that V12 told her that she (V1) is not the expert, she is, and R1 is cleared to return. V1 said that they were unable to accept her back because according to her hospital notes she is still on checks, still doing room sweeps, is still experiencing anxiety, they do not have onsite behavioral health services and they do not have the resources to keep her safe for her own well-being at this point. On 4/9/26 at 8:05 AM, V12 (Hospital Psychiatric Nurse Practitioner) said that she saw R1 in the emergency room when she admitted . V12 said that at that time, R1 said that she had a moment of impulse due to stress from moving to the permanent side of the nursing home. V12 said that when she saw R1, she was tearful, very apologetic and had regretted what she did. V12 said that R1 did not look well and looked like she had not showered. V12 said that when she saw R1 the next day, she was up in her chair and had let the staff give her a shower. V12 said that R1 was in good spirits. V12 said that R1 stabilized and was no longer meeting criteria for admission so she was going to discharge her back to the nursing home. V12 said that they adjusted her hydroxyzine (for anxiety) to every 6 hours as needed (which she was on before) and she had only been using it about once a day. V12 said that R1 was not voicing any self-harm or suicidal thoughts. V12 said that she then heard that the nursing home was not allowing R1 to return so she contacted them. V12 said that the only psychiatric care needs that R1 was in need of was to follow up with a psychiatric professional for medication monitoring and management. V12 said that R1 was still on 15 minute checks at the hospital because that is the protocol for all patients on the unit. V12 said that she would not require (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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V4 said that she felt that she was in no way safe to come back so soon. V4 said that she did not feel that R1 would be safe to return to the facility without being on 1:1 or every 15 minute checks. V4 said that when people try and kill themselves, they typically are monitored more than what a nursing home can do. On 4/9/26 at 2:55 PM, V3 (Facility Contracted Psychiatric Nurse Practitioner) said that they do have a psychologist on staff that does provide counseling to residents at the facility on a weekly or biweekly basis. V3 said that she did hear today that the facility is going back and forth on if she is going to be able to return or not return. V3 said that she has not talked to R1 or the hospital staff to be able to tell if she felt that it was safe for her to return to the facility or not. R1's Electronic Medical Record (EMR) does not document that the resident was assessed on her proposed discharge from the hospital 4/2/26. Between 4/1/26 and 4/9/26, there were no assessments of R1 documented. There were no documented notes in R1's EMR regarding her proposed return nor what needs could not be met by the facility. On 4/9/26 at 11:50 AM, V12 (Hospital Psychiatric Nurse Practitioner) said that the facility did not have R1 evaluated by a medical professional prior to providing her an involuntary discharge. V12 said that the facility did not give the patient even the opportunity to get better before giving her a discharge. V12 said that they just decided immediately that they were not going to take her back. V12 said that a lot of facilities come to the hospital and do an assessment of the resident once they have been stabilized to make sure they are able to meet their needs but this facility did not do that. The answer was that they gave her an involuntary discharge, and they were not taking her back. R1's Psychiatry Nurse Practitioner Daily Progress Notes dated 4/1/26 at 10:15 shows, Patient seen today for follow up.Patient is sitting up in a wheelchair. Patient is A&O x 4 (Alert and Oriented). Patient denies SI/HI (Suicidal Ideation/Homicidal Ideation). Patient has been isolating to her room this morning. She is tearful and states she is afraid to be here. She states that she has accepted that her husband cannot care for her and asks to return to the nursing home, where she feels safe.Unit Status/Precaution: SP (Suicide Precautions), low.R1's Progress Notes by V12 dated 4/2/26 at 2:15 PM shows,. facility was unwilling to take patient back to the facility due to regulation that would require 1:1 monitoring for a minimum of 30 days. When asked to provide this exact regulation, she was unable to.It was explained that patient was moved to a low safety level at 9:00 AM.Discussed that patient expressed deep regret and remorse for a moment of impulsivity during an episode of emotional dysregulation.Discussed that patient has shown marked improvement in less than 24 hours from the initial meeting yesterday. [V1] stated the facility could not meet the patient's needs because they do not have mental health services available.They only come once every two weeks. This writer stated patient should not require being seen more than that.discussed patient is cleared for discharge and should be able to return to their facility today.continued to refuse, stating the facility could not meet the patient needs despite this conversation from the current treatment team. R1's Nurse Practitioner Note by V6 (General Nurse Practitioner) dated 3/31/26 show, We are no longer able to meet her needs and welfare as we have no on-site psychiatry and are unable to provide 1:1 supervision for her.R1's Communication Note dated 3/31/26 shows, Bed Hold Policy, Emergency IVD, and Form 5 brought to emergency room to deliver to the resident at the hospital.On 4/9/26 at 8:05 AM, V12 said that R1 is still currently on the behavioral unit at the hospital. R1's Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents Form shows that R1 was emergently (continued on next page)

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