STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145857	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven of St. Elmo	221 East Cumberland St Elmo, IL 62458

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure timely acquisition of a medication refill resulting in missed doses of a controlled substance for 1 (R1) of 3 residents reviewed for pharmacy services in the sample of 9. This past noncompliance occurred between 4/22/26 and 4/29/26. Findings included:R1's admission Record documented admission to the facility on 9/27/2024 and included diagnoses of type 2 diabetes mellitus without complications, unsteadiness on feet, cerebral infarction, unspecified, insomnia, and anxiety disorder, unspecified. R1's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R1's cognition is intact. Under Section N, High-Risk Drug Classes, the MDS documented R1 was taking an antianxiety medication. R1's Physician Order Summary (POS) documented a discontinued order of Diazepam 5 MG (milligram) tablet by mouth four times a day (8:00 AM, 12PM, 4PM, 8PM) related to anxiety disorder with a start date of 9/22/2025 and a discontinued date of 4/28/2026. On 5/6/2026 at 10:25 AM, V4 (Family) stated she had come to the facility on 4/26/2026 around 7:00 PM because R1 told her on the phone that he was not feeling well. V4 stated she knew R1 had not been getting his Diazepam for 3-4 days prior to this day. V4 stated R1 takes Diazepam 5mg four times a day for agitation, and the facility had not been able to get his medication refilled. V4 stated she had asked several days in a row about the medication and was told that they were waiting for a script to be signed from V7 (Physician). On 5/6/2026 at 10:30 AM, R1 stated he had been taking Diazepam 5mg by mouth four times a day since he was about [AGE] years old. R1 stated it helps him to not be agitated. R1 stated he had not been getting the medication for a few days around 4/23/2026, but he did not know why. R1 stated he could tell he wasn't getting the medicine because he continued to be agitated, and it increased instead of decreased like it does when he takes his medicine. On 5/6/2026 at 10:48 AM, V5 (Registered Nurse/RN) stated she has direct patient care with R1. V5 stated she remembered R1 not having the Diazepam available and sent a script to V7's (Physician) sometime on 4/20/2026. V5 stated she believes there were multiple requests sent to V7's office with no return script that week. V5 stated V2 (Director of Nursing/DON) and V3 (Assistant Director of Nursing/ADON) also requested the Diazepam be refilled to V7's office. V5 stated R1's Diazepam 5mg by mouth four times a day was received at the facility on 4/28/2026. V5 stated she did not contact V7's office to verify if the script had been received. V5 stated she probably could have called V8 (Medical Director) to fill this prescription, but she did not. On 5/6/2026 at 10:55 AM, V3 (ADON) stated she does not work on Mondays or Fridays. V3 stated she was working on narcotic counts for residents on 4/21/2026 when V5 (Registered Nurse/RN) made V3 aware that V5 had sent a script to V7's (Physician) office for the refill of R1's Diazepam 5MG by mouth four times a day, and V3 stated she believed it was around 4/20/2026. V3 stated within the next few days she was notified R1 was out of his Diazepam and was waiting on a script to be signed by V7. V3 stated she sent a script to V7's office on 4/23/2026 to refill R1's Diazepam 5MG by mouth four times a day. V3 stated V7 responded to her message via text on 4/28/2026 that he saw the script on 4/24/2026 that V3 sent, however, he had been out of the office. V3 stated V2 (DON) took over getting R1's Diazepam refilled (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after the 4/28/2026 message. V3 stated the nursing staff should have followed up on R1's refill request and if V7 had not been in the office, the nursing staff should have contacted the on-call physician or V8 (Medical Director) to refill the prescription. On 5/6/2026 at 11:00 AM, V2 (DON) stated she was made aware that V4 (Family) wanted R1 sent out to the local emergency room on 4/26/2026 because he had been out of his Diazepam 5MG by mouth four times a day since 4/22/2026 at 8:00 PM. V2 stated R1 was admitted to the local hospital for withdrawal symptoms from not taking his Diazepam. V2 stated the nursing staff should have followed up on R1's refill script in a timely manner. V2 stated the nursing staff could have reached out to V11 (Psych Physician) or V8 (Medical Director) to refill R1's medication. On 5/6/2026 at 11:15 AM, V6 (Licensed Practical Nurse/LPN) stated she worked on 4/24/2026 through 4/26/2026 and had direct patient care with R1. V6 stated she came in on 4/24/2026 and received report that R1 had been without his Diazepam 5MG by mouth four times a day for a few days and the facility was waiting on a script from V7 (Physician). V6 stated she called V7's office and they returned a call to her to notify her that they were unable to send a script to the facility's pharmacy. V6 stated she then requested them to send it to her. V6 stated the office called back and notified her they sent the script around 4:30 PM. V6 stated their pharmacy called and notified her the script had not been signed by a physician and by that time, V7's office was closed. V6 stated on 4/26/2026 she attempted to get R1's Diazepam refilled by V9 (On-Call Physician) but he was not near a fax machine or printer. V6 stated she did not reach out to V8 (Medical Director) to request a refill for R1's medication because she is still new and learning about who she could call or reach out to in this type of situation. On 5/6/2026 at 11:21 AM, V1 (Administrator) stated his expectation is for nursing staff to follow the facility policy and procedures on medication administration, physician orders, and follow-up in a timely manner. On 5/6/2026 at 11:42 AM, V7 (Physician) stated R1 went to the local emergency room on 4/26/2026 for withdrawals due to not having his Diazepam as ordered. V7 stated he had been out of town when the facility faxed the script to his office. V7 stated the facility should have reached out to V8 (Medical Director) or V9 (On-Call Physician) if there were any issues with refilling R1's medication. V7 stated his office notified the facility on 4/24/2026 that V7 had not been in the office and the facility's pharmacy does not allow a nurse practitioner's signature for this medication. V7 stated once the facility had been notified, they should have reached out to V8 or V9 in a timely manner. On 5/6/2026 at 1:22 PM, V3 (ADON) stated she does weekly narcotic reviews and places orders for refills on medications. V3 stated Diazepam 5 MG tablet is available in the facility emergency kit but could not be accessed without R1 having an active script on hand at the facility pharmacy. On 5/6/2026 at 1:22 PM, the facility emergency kit was observed with V3 present and showed Diazepam 5 MG tablets available. On 5/7/2026 at 9:22 AM, V12 (RN) stated she worked on 4/26/2026 when R1 went to the local emergency room. V12 stated V4 (Family) requested R1 be sent to the local emergency room because he had been without his Diazepam for a few days. V12 stated until then, she was not aware R1 had been out of this medication. V12 stated R1 did have symptoms of shakiness and complained of anxiety. V12 stated she sent R1 to the local emergency room with V4 (Family) as requested. V12 stated she explained to V4 that the facility had not been able to get R1's Diazepam 5mg script signed by V7 (Physician), it was the weekend so they would not be able to get it filled. V12 stated she was aware that the facility pharmacy would take a verbal order from the physician, but they were unable to reach V7. V12 stated she thinks there may have been a nurse practitioner on call, but they did not reach out to them because they would just send them to the local emergency room for further evaluation. V12 stated she is not sure if she could have called V8 (Medical Director) to have R1's script filled. On 5/7/2026 at 12:23 PM, V15 (Pharmacist) stated the pharmacy company does have documentation showing a script for R1's Diazepam 5MG by mouth four times a day with R1 being on this medication for a while. V15 stated the documentation showed a script had been sent to them on 4/24/2026 by V7's office but had not been signed. V15 stated the pharmacy did notify the facility and physician's office the script had not been signed. V15 said the facility received a signed script on 4/27/2026. V15 stated the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pharmacist would have accepted a verbal order by a physician or nurse practitioner with appropriated credentials to refill R1's Diazepam. V15 said with an active order on file and the medication being available in the emergency kit, R1 could have received his medication. The facility's Controlled Substance Prescriptions (effective date 10/14/2026) documented under Policy: Before a controlled drug can be dispensed, the pharmacy must be in a receipt of a clear, complete, and signed written prescription from a person lawfully authorized to prescribe. Verbal orders for controlled medications are permitted for class II-controlled drugs only in emergency situations. The facility's Emergency Pharmacy Service and Emergency Kits (effective date 10/14/2026) documented under Policy: Emergency pharmacy services is available on a 24-hour basis. Emergency needs for medication are met by using the facility's approved Emergency Medication Kit/Box or by special order from pharmacy. The pharmacy supplies emergency mediations including emergency drugs, antibiotics, controlled substances, and products for infusion in limited quantities in compliance with applicable state and federal regulations to serve the immediate clinical needs of the residents. Documented under Procedures: A. Telephone/fax numbers for emergency services are posted at nursing stations. B. The dispensing pharmacy is called if an emergency arises requiring immediate pharmacist consultation concerning appropriateness of therapy, drug information, etc. Prior to the survey date, the facility took the following actions to correct the non-compliance dated 4/28/2026:1. Actions taken to correct deficiencies.a. Resident was sent to the hospitalb. New fax machine acquiredc. Nurse Practitioner to provide backup to provider when provider is not available. 2. Actions taken to identify other potential residents affected by the deficient practice dated 4/28/2026:a. All current residents that receive antianxiety medication are at risk for deficient practice. 3. Actions taken to ensure proper practice continues dated 4/28/2026:a. Audit completed of all residents taking antianxiety medication in the facility to ensure all residents antianxiety medication available.b. Education to nursing staff on the process for controlled medication ordering.c. Director of Nursing/Designee will audit antianxiety medication availability for residents daily for 1 week, 3 times a week for 2 weeks, and weekly for one month. 4. Actions taken to ensure the deficient practice does not recur, dated 4/29/2026:On April 29, 2026, the interdisciplinary team reviewed the medication error to determine contributing factors and implement corrective actions. The event was analyzed to identify opportunities for improvement in medication administration and communication processes. There are steps that have been put in place to reduce the risk of recurrence and to promote safe and effective medication practices for all residents. Trends will be reported to the Quality Assurance Committee for review with any identified deficiencies to have further corrective action implemented as needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer an antianxiety medication for 1 (R1) of 3 residents reviewed for medication errors in the sample of 9. The failure resulted in R1 developing withdrawal symptoms including nausea, vomiting, shaking, agitation, and being admitted to the local hospital for 2 days.This past noncompliance occurred between 4/22/26 and 4/29/26.Findings include: R1's admission Record documented an admission date to the facility on 9/27/2024 and included diagnoses of type 2 diabetes mellitus without complications, unsteadiness on feet, cerebral infarction, unspecified, insomnia and anxiety disorder, unspecified.R1's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R1's cognition is intact. Under Section N, High-Risk Drug Classes the MDS documented R1 takes an antianxiety medication.R1's Care Plan documented a Focus Area of diagnosis of anxiety and is in need of anti-anxiety medication to treat his condition with interventions that included anti-anxiety medication per doctor's orders.R1's Physician Order Summary (POS) documented a discontinued order of Diazepam 5 MG (milligram) tablet by mouth four times a day (8:00 AM, 12PM, 4PM, 8PM) related to anxiety disorder with a start date of 9/22/2025 and a discontinued date of 4/28/2026.On 5/6/2026 at 10:25 AM, V4 (Family) stated she came to the facility on 4/26/2026 around 7:00 PM because R1 told her on the phone that he was not feeling well. V4 stated she had known R1 had not been getting his Diazepam for 3-4 days prior to this day. V4 stated R1 takes Diazepam 5mg four times a day for agitation, and the facility had not been able to get his medication refilled. V4 stated she had asked several days in a row about the medication and had been told that they were waiting for a script to be signed from V7 (Physician). V4 stated when she arrived at the facility on 4/26/2026, R1 was weak, shaking, nauseated, had vomited and stated he could not eat the last 2 days. V4 stated she requested R1 be sent to the local emergency room. V4 stated R1 was admitted to the local hospital for a few days with a diagnosis of withdrawal from diazepam. V4 stated R1 returned to the facility on 4/28/2026 and the facility had received the medicine by the time R1 returned.On 5/6/2026 at 10:30 AM, R1 stated he had been taking Diazepam 5mg by mouth four times a day since he was about [AGE] years old. R1 stated it helps him to not be agitated. R1 stated he had not been getting the medication for a few days around 4/23/2026, but he did not know why. R1 stated he could tell he wasn't getting the medicine because he continued to be agitated, and it increased instead of decreased like it does when he takes his medicine. R1 stated he went to the local emergency room on 4/26/2026 where they admitted him for having withdrawals from not taking his Diazepam for 3-4 days. R1 stated he had been weak, nauseous, unable to eat, very agitated and had vomited once.On 5/6/2026 at 10:48 AM, V5 (Registered Nurse/RN) stated she has had direct patient care with R1. V5 stated she remembers R1 not having his Diazepam available and sent a script to V7 (Physician) sometime on 4/20/2026. V5 stated she believes there were multiple requests sent to V7's office with no return script that week. V5 stated V2 (Director of Nursing/DON) and V3 (Assistant Director of Nursing/ADON) also requested R1's Diazepam be refilled to V7's office. V5 stated V2 (Director of Nursing/DON) and V3 (Assistant Director of Nursing/ADON) also requested the Diazepam be refilled to V7's office. V5 stated R1's Diazepam 5mg by mouth four times a day was received at the facility on 4/28/2026. V5 stated she did not contact V7's office to verify if the script had been received. V5 stated she probably could have called V8 (Medical Director) to fill this prescription, but she did not. V5 stated R1 went out to the local hospital on 4/26/2026.On 5/6/2026 at 10:55 AM, V3 (ADON) stated she does not work on Mondays or Fridays. V3 stated she was working on narcotic counts for residents on 4/21/2026 when V5 (Registered Nurse/RN) made V3 aware that V5 had sent a script to V7's (Physician) office for the refill of R1's Diazepam 5MG by mouth four times a day, and V3 stated she believed it was around 4/20/2026. V3 stated within the next few days she was notified R1 was out of his Diazepam and was waiting on a script to be signed by V7. V3 stated (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	she sent a script to V7's office on 4/23/2026 to refill R1's Diazepam 5MG by mouth four times a day. V3 stated R1 went to the local emergency room on 4/26/2026 and was admitted for withdrawal symptoms from not receiving his Diazepam.On 5/6/2026 at 11:00 AM, V2 (DON) stated was made aware that V4 (Family) wanted R1 sent out to the local emergency room on 4/26/2026 because he had been out of his Diazepam 5MG by mouth four times a day since 4/22/2026 at 8:00 PM. V2 stated R1 was admitted to the local hospital for withdrawal symptoms from not taking his Diazepam.On 5/6/2026 at 11:15 AM, V6 (Licensed Practical Nurse/LPN) stated she worked on 4/24/2026 through 4/26/2026 and had direct patient care with R1. V6 stated she came in on 4/24/2026 and received report that R1 had been without his Diazepam 5MG by mouth four times a day for a few days and the facility was waiting on a script from V7 (Physician). V6 stated R1 was admitted to the local hospital on the evening of 4/26/2026 with withdrawal symptoms from not taking his Diazepam.On 5/6/2026 at 11:21 AM, V1 (Administrator) stated his expectation is for nursing staff to follow the facility policy and procedures on medication administration, physician orders, and follow-up in a timely manner.On 5/6/2026 at 11:42 AM, V7 (Physician) stated R1 went to the local emergency room on 4/26/2026 for withdrawals of not having his Diazepam as ordered. V7 stated he had been out of town when the facility faxed the script to his office. V7 stated the facility should have reached out to V8 (Medical Director) or V9 (On-Call Physician) if there were any issues with refilling R1's medication. V7 stated his office notified the facility on 4/24/2026 that V7 had not been in the office and the facility's pharmacy does not allow a nurse practitioner signature for this medication. V7 stated once the facility was notified, they should have reached out to V8 or V9 in a timely manner.On 5/6/2026 at 1:22 PM, V3 (ADON) stated she does weekly narcotic reviews and places orders for refills on medications. V3 stated Diazepam 5 MG tablet is available in the facility emergency kit but could not be accessed without R1 having an active script on hand at the facility pharmacy.On 5/6/2026 at 1:22 PM, the facility emergency kit was observed with V3 present and showed Diazepam 5 MG tablets available.On 5/7/2026 at 9:05 AM, V6 (LPN) stated R1 did not complain of any symptoms of withdrawal from his Diazepam to her until 4/26/2026. V6 stated R1 complained of shakiness, agitated, etc. V6 stated she notified V2 (DON) on 4/24/2026 that she was unable to get R1's Diazepam.On 5/7/2026 at 9:22 AM, V12 (RN) stated she worked on 4/26/2026 when R1 went to the local emergency room. V12 stated V4 (Family) requested R1 be sent to the local emergency room because he had been without his Diazepam for a few days. V12 stated until then, she was not aware that R1 was out of his medication. V12 stated R1 had symptoms of shakiness and complained of anxiety. V12 stated she sent R1 to the local emergency room with V4 as requested.R1's Progress Notes dated 4/22/2026 at 9:43 PM by V13 (LPN), 4/23/2026 at 8:12 AM by V14 (RN), 4/23/2026 at 12:00 PM by V14 (RN), 4/23/2026 at 5:03 PM by V14 (RN), 4/24/2026 at 12:29 AM by V13 (LPN), 8:46 AM by V6 (LPN), 11:39 AM by V6, 3:52 PM by V6, 8:36 PM by V12 (RN), 4/25/2026 at 8:28 AM by V6, 11:08 AM by V6, and 4:57 PM by V6 (LPN) all documented R1's diazepam 5mg tablet by mouth four times a day was not available, waiting on order, or waiting on script.R1's Medication Administration dated April 1st - April 30th documented Diazepam 5MG tablet by mouth four times a day was not administered on 4/22/2026 at 9:43 PM by V13 (LPN), 4/23/2026 at 8:12 AM by V14 (RN), 4/23/2026 at 12:00 PM by V14 (RN), 4/23/2026 at 5:03 PM by V14 (RN), 4/24/2026 at 12:29 AM by V13 (LPN), 8:46 AM by V6 (LPN), 11:39 AM by V6, 3:52 PM by V6, and 8:36 PM by V12 (RN), and 4/25/2026 at 8:28 AM by V6, 11:08 AM by V6, and 4:57 PM by V6 (LPN).R1's Progress Note dated 4/26/2026 at 1:38 AM by V12 (RN) documented R1 had complaints of shaking, diarrhea, sinus drainage into chest, and congestion. (V4) was here and wanted to escort resident to the hospital at 7:20PM. This RN just received a call from the local emergency room stating they are keeping R1 with a diagnosis of Diazepam withdraw.R1's Progress Note dated 4/26/2026 at 6:20 AM by V6 (LPN) documented R1 was admitted to the hospital.R1's local hospital After Visit Summary dated 4/26/2026 - 4/28/2026 documented under Reason for admission: Valium (Diazepam) withdrawal.The facility's policy Medication Administration (effective date 10/25/2014) documented under Policy: Medications are administered as prescribed in accordance with good nursing principles (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	and practices and only by persons legally authorized to do so. Under Procedure:.Administration.2) Medications are administered in accordance with written orders of the prescriber.According to https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/013263s094lbl.pdf, Diazepam is a benzodiazepine that exerts anxiolytic, sedative, muscle relaxant, anticonvulsant and amnestic effects. Withdrawal symptoms, similar in character to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of diazepam. These withdrawal symptoms may consist of tremor, abdominal and muscle cramps, vomiting, sweating, headache, muscle pain, extreme anxiety, tension, restlessness, confusion and irritability.Prior to the survey date, the facility took the following actions to correct the non-compliance:1. Actions taken to correct deficiencies dated 4/28/2026Resident was sent to the hospitalNew fax machine acquiredNurse Practitioner to provide backup to provider when provider is not available.2. Actions taken to identify other potential residents affected by the deficient practice dated 4/28/2026: a. All current residents that receive antianxiety medication are at risk for deficient practice.3. Actions taken to ensure proper practice continues dated 4/28/2026:Audit completed of all residents taking antianxiety medication in the facility to ensure all residents antianxiety medication available.Education to nursing staff on the process for controlled medication ordering.Director of Nursing/Designee will audit antianxiety medication availability for residents daily for 1 week, 3 times a week for 2 weeks, and weekly for one month.4. Actions taken to ensure the deficient practice does not recur, dated 4/29/2026:On April 29, 2026, the interdisciplinary team reviewed the medication error to determine contributing factors and implement corrective actions. The event was analyzed to identify opportunities for improvement in medication administration and communication processes. There are steps that have been put in place to reduce the risk of recurrence and to promote safe and effective medication practices for all residents. Trends will be reported to the Quality Assurance Committee for review with any identified deficiencies to have further corrective action implemented as needed.