STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145910	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calhoun Nursing & Rehab Center	#1 Myrtle Lane Hardin, IL 62047

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. (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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the Facility failed to involve the resident and resident representative in the development of the discharge plan and inform the resident and representative of the final plan in 1 of 3 residents (R2) reviewed for transfer and discharge in the sample of 3. This failure resulted in a disruption in R2's environment, causing reorientation issues and worsening confusion. This past non-compliance occurred from 7/18/25 to 7/21/25.Findings include:R2's Face Sheet documents R2 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease and diabetes mellitus.R2's Minimum Data Set (MDS) dated [DATE] documented R2 was severely cognitively impaired, ambulated independently, wandered daily, and had both verbal and other behaviors one to three days per week.R2's Care Plan does not address any plan for discharge.R2's 7/6/25 Progress Note by V9, Licensed Practical Nurse (LPN), documents V10 and V7, R2's Family, were looking for a facility for R2 with a locked memory unit but were still trying to decide between two facilities.R2's 7/17/25 Progress Note by V11, LPN, documents R2 will be discharging to another facility on 7/18/25. The note did not document any correspondence with family.R2's Progress Notes do not document V7 or V10 were involved in the development of the final plan or informed of the final plan.On 8/19/25 at 10:39 AM, V7 stated she is R2's Power of Attorney (POA), she did not sign any discharge paperwork for R2, and nobody told her R2 was discharging from the Facility. V4, Social Services Director, previously mentioned to the family that R2 would eventually need a higher level of care, but said there was no rush. V7 had not heard any more about it until on 7/18/25 when V8, R2's Family, got a call from V6, R2's Family, stating he saw R2 at a new Facility. V7 stated, (R2) is not a dog, you can't just dump them off like an animal, like they are trash; that's not fair. V7 stated every time R2 moves to a new facility, her dementia seems to get worse.On 8/19/25 at 8:15 AM, V1, Administrator, stated R2 had worsening dementia. V3, Director of Admissions, and V4 had talked to her family about placing her in a dementia unit. We found a facility with a dementia unit and planned to send R2 there when a bed was ready, but when there finally was a bed ready, nobody sent the family a notification that she was discharged . On 8/19/25 at 8:40 AM, V3 stated she spoke with V8 about R2's worsening dementia and R2 possibly being better off in a dementia unit. V8 stated she would discuss this with V7 and get back to her. V3 notified the accepting facility that R2's family was considering transferring there and would get back to them. V3 later heard R2 would be leaving the Facility on 7/18/25 and assumed someone else had talked to the family, but apparently nobody did. It was all a miscommunication. Apparently V6 was finishing up a stay at the accepting facility when R2 arrived. He saw her and called V7, and that is when it hit the fans.On 8/19/25 at 9:00 AM, V4 stated R2's discharge was a big miscommunication. She and V1 had been talking with R2's family regarding discharge, but R2 was discharged and the family was not made aware she would be transferring that day.On 8/19/25 at 11:18 AM, V1 stated there is no official transfer paperwork. It was just presumed that they had consent and it was ok to transport him in the van.On 8/19/25 at 11:25 AM, V1 stated typically discharges are initiated by the team/family/resident, then referrals are sent out to the facility, the facility is contacted to coordinate a date/time, the physician is contacted for orders, and the family is notified.The Facility's Discharge and Transfer Policy revised 4/2025 documents, Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. The facility will provide sufficient orientation to residents to ensure safe and orderly transfer or discharge from the facility including an opportunity to participate in deciding where to go. If transferred to another health care facility upon order of a physician, a two-copy transfer form is completed. One copy is sent with the resident and the other is filed in the resident's record. Prior to resident being transferred or discharged , the facility must provide a written notice to the resident, and if known, a family member or legal representative of the resident. This must be issued at least 30 days before the resident is transferred or discharged or as soon as practicable for immediate transfers or the resident has not resided in the facility for 30 days. The written discharge/transfer notice must contain the following information: a. The reason for transfer or discharge; b. The effective date of transfer or discharge; c. The location to which the resident is transferred or discharged . Prior to the survey date of 8/19/25, the Facility had taken the following action to correct the non-compliance:On 7/21/25, V1, V2, and V4 were educated by V12 regarding discharge planning to ensure responsible parties were notified of discharges and transfers.On 7/21/25, an Ad Hoc QAPI Meeting including V13, Medical Director, was held to identify issue and discuss the development of a past non-compliance to address V2 is reviewing discharges

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the Facility failed to document notice of transfer requirement for 1 of 3 residents (R2) reviewed for transfer and discharge in the sample of 3. This past non-compliance occurred from 7/18/25 to 7/21/25.Findings include:R2's Face Sheet documents R2 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease and diabetes mellitus.R2's Minimum Data Set (MDS) dated [DATE] documented R2 was severely cognitively impaired, ambulated independently, wandered daily, and had both verbal and other behaviors one to three days per week.R2's Care Plan does not address any plan for discharge.R2's 7/17/25 Progress Note by V11, LPN, documents R2 will be discharging to another facility on 7/18/25.R2's Progress Notes do not document R2's discharge notice was given or family was contacted regarding R2's discharge.On 8/19/25 at 10:39 AM, V7, R2's Family, stated she is R2's Power of Attorney (POA) and was never notified of R2's discharge by the Facility.On 8/19/25 at 1:55 PM, V1, Administrator, stated he would expect the medical record to contain documentation that notification was made to the resident's representative and a discharge notice was given.The Facility's Discharge and Transfer Policy revised 4/2025 documents, Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Prior to resident being transferred or discharged , the facility must provide a written notice to the resident, and if known, a family member or legal representative of the resident. This must be issued at least 30 days before the resident is transferred or discharged or as soon as practicable for immediate transfers or the resident has not resided in the facility for 30 days. The written discharge/transfer notice must contain the following information: a. The reason for transfer or discharge; b. The effective date of transfer or discharge; c. The location to which the resident is transferred or discharged .Prior to the survey date of 8/19/25, the Facility had taken the following action to correct the non-compliance:On 7/21/25, V1, V2, and V4 were educated by V12 regarding discharge planning to ensure responsible parties were notified of discharges and transfers.On 7/21/25, an Ad Hoc QAPI Meeting including V13 was held to identify issue and discuss the development of a past non-compliance to address. V2 is reviewing discharges and transfers five days a week for 60 days, then three times a week for four weeks, then monthly to ensure compliance.