

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146086	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER The Haven of Tuscola		STREET ADDRESS, CITY, STATE, ZIP CODE 1203 Egyptian Trail Tuscola, IL 61953	
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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure pain medication supply was available for administration for two residents (R1 and R2), failed to clarify a physician order for a pain medication dose for one resident (R2), and failed to initiate a care plan for pain triggered on a Care Area Assessment (CAA) for one resident (R2). These failures affected two (R1 and R2) of three residents reviewed for pain on the sample list of three residents. This failure resulted in R1, going without needed Morphine narcotic pain medications, during end-of-life (Hospice) comfort focused care, for greater than 24 hours. This failure resulted in R2 going without Lidocaine (topical numbing agent, for nerve ending) patch for pain, continually for five days which prevented R2's ability to sleep comfortably. 1. R1's Electronic Health Record (EHR) contains a nursing note dated 7/9/26 that documents R1 arrived at the facility at 11:30 a.m. via ambulance. R1's Physician Order Sheet (POS) dated 7/9/26 documents an order for Morphine Sulfate (Concentrate) Oral Solution 20 milligrams (mg) per milliliter (ml), give 10 mg sublingually every one hour as needed for pain and/or air hunger. R1's July 2026 Medication Administration Record (MAR) documents no administration of Morphine Sulfate on 7/9/26. This MAR also included an order for pain monitoring every shift; however, no pain monitoring was documented on 7/9/26. During the day shift on 7/10/26, the MAR documented that R1 rated the pain as five out of ten. R1's MAR further documents that R1 received the first dose of Morphine Sulfate on 7/10/26 at 1:41 p.m., approximately 26 hours after admission to the facility. R1's EHR contains a Hospice admission Note dated 7/9/26 that documents R1 was admitted to hospice with a diagnosis of End Stage Heart Failure. R1's Care Plan dated 7/10/26 documents R1 has a terminal condition and is at risk for loss of dignity during the dying process and at risk for unavoidable significant decline with a goal that R1's comfort will be maintained through the review date. This Care Plan documents an intervention for staff to monitor R1 for signs of pain, administer pain medications as ordered, and notify physician immediately if there is breakthrough pain. R1's Hospice Care Plan, dated 7/9/26, identified pain/physical discomfort as a problem area for R1. The care plan established a goal that R1's pain/physical discomfort would be reduced or maintained (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 0697 Level of Harm - Actual harm Residents Affected - Few	at or below the level identified in the patient's stated goal throughout the hospice episode. The care plan also included a pain management intervention instructing the facility nurse, resident, and caregiver on the medications used for pain management and to contact hospice if pain relief was unsatisfactory. R1's EHR contains a nursing note dated 7/10/26 that documents R1's family requested as needed pain medication; for R1 however, nursing staff were unable to locate the medication. Follow-up with hospice and the pharmacy revealed the prescriptions had not been received and were pending clarification regarding the pharmacy to receive the orders. The note documented that R1's family reported R1 had not received Morphine for 24 hours and requested the medication be sent to another pharmacy due to concerns about delayed delivery. On 7/31/2026 at 10:01 a.m., V4 Pharmacy Technician stated that the pharmacy received orders on 7/9/26 for R1; however, there was no order for morphine. On 7/31/2026 at 10:07 a.m., V5 Order Entry Manager for the facility pharmacy stated that the pharmacy received physician orders for R1 on 7/9/2026; however, those orders did not include an order for morphine. On 7/31/2026 at 12:59 p.m., V13 a Certified Nursing Assistant (CNA) stated that while providing R1 a bath on the day of admission, R1 appeared uncomfortable during repositioning, as evidenced by grunting with movement. On 7/31/2026 at 12:45 p.m., V14 Regional Nurse Consultant stated that facility policy requires nursing staff to use the local backup pharmacy when medications are not immediately available and to exhaust all efforts to obtain ordered medications without delay. V14 stated that staff should have taken these actions to ensure timely administration of the ordered pain medication to R1. 2. R2's Current Diagnoses list documents the following: R2 Current Diagnoses Sheet includes the following: Other Intervertebral Disc Degeneration, Lumbar Region with Discogenic Back Pain, Functional Quadriplegia, and Muscle Wasting and Atrophy, Not Elsewhere Classified, Multiple Sites, and Abnormal Posture. R2's Minimum Data Set (MDS) dated [DATE] documents the following: R2's Brief Interview of Mental status score as 11 out of a possible 15, indicating moderate cognitive impairment at the time of the assessment. R2's same MDS documents R2 had occasional moderate- severe pain intensity as reflected by the score of six out of ten on the standard pain scale 00-10, 10 being the worst pain. R2's Minimum Data Set - CAA (Care Area Assessment) documents R2's Pain Problem triggered to be carried over to R2's Care plan. R2's Current Care Plan does not document a care area category to direct staff on how to provide relief for R2's pain. R2's July 1-31, 2026, Physician Order Sheet documents the following: Lidocaine External Patch (Lidocaine), apply to affected area topically, one time a day for Mild Pain. (There is no identified (continued on next page)		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	dose), Acetaminophen (Tylenol) Oral Tablet 500 MG (extra strength/ milligram), Give 1 (one) tablet by mouth, every 4 (four) hours, as needed for Pain; Fever/Elevated Temperature. R2's July 1-31, 2026, Medication Administration Order (MAR) documents the following medication doses were not administered: Lidocaine External Patch (Lidocaine) Apply to affected areas topically one time a day for Mild Pain -Start Date-07/14/2026 at 0600 am documents the number nine which direct reader to see the nurses' notes on 7/26/26, 7/27/26, (7/28/26 was signed off as given, was in error per DON interview), 7/29/26 and 7/30/26. Corresponding Nurse progress note each document Lidocaine medication patch was out of stock. R2's same Medication Administration Record documents R2 was administered Tylenol 500 mg by mouth on 7/31/26 at 1:20 am for a pain level of five (different than R2's interview below of seven or eight) out of ten (moderate pain). On interview with R2 documented below R2's pain level was seven &ndash; eight (very strong) which resulted in poor sleep. On 7/31/26 at 10:20 am, R2 was seated bedside in a specialty wheelchair. R2 was restless, shifting R2's weight back and forth. R2 stated I have not had my Lidocaine Patch on (applied), for several days. I have never refused the nurses when they put one (Lidocaine patch) on me. I need them (Lidocaine patch), every day. I have asked a few different nurses (unidentified) to put one on me, and they all say they don't have any, but they have ordered more of them. I was real miserable last night. I could not get to sleep. My back pain was between seven (7) or eight (8), out of 10 ten. (standard pain scale is 1-10 range with 10 being the most severe). The night nurse (unidentified) gave me the real strong Arthritis Tylenol. That seven to eight-pain level is a lot more pain than I have had this week, without my patch (lidocaine). My pain was around five (5) out of ten after I got the emergency Tylenol from the night nurse. I could sleep (after Tylenol administration) but I would still wake up hurting. When I wear my patch my pain level is maintained at two out of ten. I can tolerate that. I will be asking for Tylenol again soon. You can see I am fidgety. My back is hurting now, at about five or six, again. On 7/31/26 at 11:03 am V6 (R2's) Family Member stated (R2) is almost 90, (R2) has pain all the time. The Lidocaine patches work to take the edge off. (R2) is not a complainer. (R2) is totally aware of when (R2) is hurting and will ask for Tylenol if (R2) has break through pain. (R2) has mentioned a few times that overnight (R2) has needed and been given (administered) Tylenol to sleep more comfortably. I was there (in the facility) for a visit on Monday (7/27/26) (R2) told me (R2) had problems sleeping the night before (7/26/26). I assumed (R2) was getting the Lidocaine patch and probably asked for Tylenol, too. On 7/31/26 at 12:05 pm, V2 Director of Nursing (DON) reviewed R2's medical record. V2 DON confirmed R2's Physician Order for the Lidocaine Patch did not include the dose, as is required for medications, to ensure the residents receive the appropriate amount of medication to treat their diagnosis. V2 also confirmed that R2 missed the application of Lidocaine medication patch on 7/26, 7/27, (DON confirmed 7/28/26 dose was likely signed in error as given, because there were no patches available), 7/29 and 7/30/26. V2 stated the missed doses were because the facility ran out of the Lidocaine medicated patches. V2 DON said that R2 received PRN (as needed) Extra Strength Tylenol for pain while waiting on the Lidocaine medicated patch. V2 DON confirmed the Lidocaine medicated patch was more specific to R2's back pain relief, where Tylenol is more for general pain. (continued on next page)		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	V2 DON confirmed that Lidocaine patches stock should have been available to maintain R2's comfort and prevent interruption of R2's sleep. On 7/31/26 at 1:25 pm, V14 Regional Nurse Consultant reviewed R2's medical records and confirmed R2's care plan does not include a category for pain to be addressed. V14 confirmed R2's Minimum Data Set - CAA (Care Area Assessment) documents R2's Pain Problem was to be carried over to R2's Care plan and interventions established, specific to R2's needs to relieve pain. V14 confirmed R2's pain medications would have been part of the intervention, and the care plan should include non-pharmacological intervention. V14 stated staff and pharmacy communication, and follow-up for obtaining medication must get better. V14 said V14's expectation is for the facility nursing staff to exhaust every effort to ensure the residents' medications are in the facility when due to be administered. The facility's Pain & Clinical Protocol policy, dated August 2008, documented that the physician is responsible for evaluating the resident's pain, including examining the resident, reviewing the resident's history, and discussing the resident's pain with the resident and staff. The policy further documented that the physician will establish pain management goals with input from the resident and/or advocate and order appropriate non-pharmacologic and pharmacologic interventions to address the resident's pain. The facility's Medication Administration policy, dated 10/25/2014, documents that medications are administered as prescribed in accordance with good nursing principles and practices and only by legally authorized personnel. The policy further documents that the facility maintains sufficient staffing and a medication distribution system to ensure safe medication administration without unnecessary interruptions. If a medication with a current, active order cannot be located in the medication cart/drawer, medication room, or other areas of the facility, the pharmacy is contacted, or the medication is obtained from the night box/emergency kit after further investigation.		

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview and record review the facility failed to obtain physician ordered medications in a timely manner, which resulted in significant medication errors due to repeated, missed administration of medication. These failures affected two (R1 and R2) of three residents reviewed for medication on the sample list of three residents. This failure resulted in R1, going without needed Morphine narcotic pain medications, during end-of-life (Hospice) comfort focused care, for greater than 24 hours. This failure resulted in R2 going without Lidocaine (topical numbing agent, for nerve ending) patch, for pain, continually for five days which prevented R2's ability to sleep comfortably and going without Mirabegron Urinary Antispasmodic medication for seven days, which increased frequency of urgency to urinate. 1. R1's Electronic Health Record (EHR) contains a nursing note dated 7/9/26 that documents R1 arrived at the facility at 11:30 a.m. via ambulance. R1's EHR contains a Hospice admission Note dated 7/9/26 that documents R1 was admitted to hospice with a diagnosis of End Stage Heart Failure. R1's Physician Order Sheet (POS) dated 7/9/26 documents an order for Morphine Sulfate (Concentrate) Oral Solution 20 milligrams (mg) per milliliter (ml), give 10 mg sublingually (under the tongue) every one hour as needed for pain and/or air hunger. R1's July 2026 Medication Administration Record (MAR) documents no administration of Morphine Sulfate on 7/9/26. This MAR further documents that R1 received the first dose of Morphine Sulfate on 7/10/26 at 1:41 p.m., approximately 26 hours after admission to the facility. R1's Medication Administration Record (MAR) dated July 2026 documents 26 potential missed doses of Morphine based on the PRN (as needed) medication order. R1's Care Plan dated 7/10/26 documents that staff should monitor R1 for signs of pain, administer pain medications as ordered, and notify physician immediately if there is breakthrough pain. On 7/31/2026 at 9:10 a.m., V7 (R1's) family member, stated that R1 did not receive the prescribed pain medication for more than 24 hours following admission to the facility. V7 stated that during this time R1 rated the pain as an eight on a scale of 0 to 10 and that the facility failed to provide the pain medication ordered to manage R1's pain because it was not available. On 7/31/2026 at 12:28 p.m., V3 Licensed Practical Nurse (LPN) stated that R1 exhibited nonverbal signs of pain on the morning of 7/10/2026 and that Morphine was not available for administration. On 7/31/2026 at 12:45 p.m., V14 Regional Nurse Consultant stated that facility policy requires nursing staff to use the local backup pharmacy when medications are not immediately available and to exhaust all efforts to obtain ordered medications without delay. V14 stated that staff should have taken these actions to ensure timely administration of the ordered pain medication to R1. (continued on next page)		

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F 0760 Level of Harm - Actual harm Residents Affected - Few	2. R2's Current Diagnoses list documents the following: R2 Current Diagnoses Sheet includes the following: Other Intervertebral Disc Degeneration, Lumbar Region with Discogenic Back Pain, Functional Quadriplegia, and Muscle Wasting and Atrophy, Not Elsewhere Classified, Multiple Sites, and Abnormal Posture. R2's July 1-31, 2026, Physician Order Sheet documents the following: Lidocaine External Patch (Lidocaine), apply to affected area topically, one time a day for Mild Pain. (There is no identified dose), Acetaminophen (Tylenol) Oral Tablet 500 MG (extra strength/ milligram), Give 1 (one) tablet by mouth, every 4 (four) hours, as needed for Pain; Fever/Elevated Temperature, and Mirabegron ER Oral Tablet Extended Release (ER) 24 Hour, 25 MG (Milligrams), Give 1 (one) tablet by mouth, every day shift for Urinary Antispasmodic. Start Date-07/11/2026 at 0600 am. R2's July 1-31, 2026, Medication Administration Order (MAR) documents the following medication were not administered: Lidocaine External Patch (Lidocaine) Apply to affected areas topically one time a day for Mild Pain -Start Date-07/14/2026 at 6:00 am documents the number nine which direct readers to see the nurses' notes on 7/26/2, 7/27/26, (7/28/26 was signed off as given was in error per DON interview), 7/29/26 and 7/30/26. Corresponding Nurse progress note each document Lidocaine medication patch was out of stock. R2's same MAR documents: Mirabegron ER Oral Tablet Extended Release 24 Hour 25 MG (Milligrams), Give 1 (one) tablet by mouth, every day shift, for Urinary Antispasmodic. Start Date-07/11/2026 at 6:00 am. The same MAR documents 7/14/26, 7/15/26, 7/16/26, 7/17/26, (on 7/18/26 it is documented that medication was administered. V2 confirmed in the interview that the medication was out of stock and was not given), 7/19/26, and 7/20/26, documents the number nine which direct readers to see the nurses' notes. Corresponding Nurse progress notes document Mirabegron medication was on order from the pharmacy. On 7/31/26 at 10:20 am, R2 confirmed R2 had not received R2's Lidocaine patches for several days which resulted in R2's inability to sleep comfortably. R2 also confirmed R2 had not received R2's Mirabegron ER medication for several days which caused R2 to have frequent, urgency to urinate. On 7/31/26 at 11:03 am, V6 (R2's) Family Member stated R2 had gone to the local hospital from another nursing home. R2 was subsequently transferred from the local hospital to this facility. V6 (R2's) Family Member said I (V6) had gone to the previous nursing home and brought what was left of (R2's) medications, (at the other facility) and brought what was left of the medications to this nursing home. That was the day after (R2) was admitted to this facility (7/10/26). V6 also said V6 had been told the nursing homes pharmacy would supply R2's medication after the medication V6 brought in, was used up. V6 also stated (R2) is almost 90, (R2) has pain all the time. The Lidocaine patches work to take the edge off. (R2) is not a complainer. R2 is totally aware of when R2 is hurting and will ask for Tylenol if R2 has break through pain. (R2) has mentioned a few times that overnight (R2) has needed and been given Tylenol to sleep more comfortably. I was there for a visit on Monday (7/27/26) (R2) told me (R2) had problems sleeping the night before. I assumed (R2) was getting the Lidocaine patch and probably asked for Tylenol, too. (continued on next page)		

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 7/31/26 at 12:05 pm, V2 Director of Nursing (DON) reviewed R2's medical record. V2 DON confirmed R2's Physician Order for the Lidocaine Patch did not include the dose, as is required for medications, to ensure the residents receive the appropriate amount of medication to treat their diagnosis. V2 also confirmed that R2 missed the application of Lidocaine medication patch on 7/26, 7/27, 7/28 was likely signed in error as given, because there were no patches available, 7/29 and 7/30/26. V2 stated the missed doses were because the facility ran out of the medicated patches. V2 DON said that R2 received PRN Extra Strength Tylenol for pain while waiting on the Lidocaine medicated patch. V2 DON confirmed the Lidocaine medicated patch was more specific to R2's back pain relief, where Tylenol is more for general pain. V2 DON confirmed that Lidocaine patches stock should have been available. V2 DON also confirmed that R2 missed Mirabegron medication on 7/14, 7/15, 7/16 though documented as administered in error, 7/17, 7/19, 7/20, and 7/21/26. Though it was ordered, the supply did not come from pharmacy, as it should have. V2 stated the facility uses (private company name) pharmacy which is (outside the state of Illinois). Generally, the medication comes in the next evening. The facility uses their convenience box backup medications or if a medication is ordered STAT (immediately), (local pharmacy) is used. V2 confirmed the convenience facility medication supply box does not contain Mirabegron, and the order was not sent to (local pharmacy). During the same review of R2's medical record, V2 Director of Nursing, said the quantity of R2's missed medication doses, and the unrelieved pain equate to 'significant' medication errors. The facility's Medication Administration policy, dated 10/25/2014, documented that medications are administered as prescribed in accordance with good nursing principles and practices and only by legally authorized personnel. The policy further documented that the facility maintains sufficient staffing and a medication distribution system to ensure safe medication administration without unnecessary interruptions. If a medication with a current, active order cannot be located in the medication cart/drawer, medication room, or other areas of the facility, the pharmacy is contacted, or the medication is obtained from the night box/emergency kit after further investigation.		