STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146104	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven of Farmer City	404 Brookview Drive Farmer City, IL 61842

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50430 Based on interview and record review the facility failed to develop a discharge plan for administration of diabetic medications and wound care for one of three residents (R2) reviewed for discharge in the sample list of six. Findings include: The facility's undated Transfer and Discharge Policy documents the facility will assure resident transfers and discharges will be conducted in accordance with resident's rights, physician orders, and in such a manner as to maintain continuity of care for the resident. The Medication Administration Record dated 3/12/25 documents orders for R2 to have blood glucose checks before meals and at bedtime, Metformin (antidiabetic)1000 milligrams (mg) in the morning and at bedtime, Trulicity (antidiabetic) 3mg subcutaneously every Thursday, and Lantus insulin 10 units (subcutaneously) every morning. The Treatment Administration Record dated 3/12/25 documents and order for R2 to have a dressing change to R2's right great toe wound daily. The facility's Release of Responsibility for Discharge against Medical Advice (AMA) form dated 3/13/25, contains R2's signature on the resident signature line, and at the bottom of the document a handwritten statement documents the consent form was read out loud to R2 because resident is unable to read. R2's medical record does not contain a discharge plan or notification of the physician of R2's 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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/25 at 9:40 AM, V1 (Administrator) stated R2 was homeless prior to his admission from the hospital on 3/12/24. V1 stated the facility ran R2's background check prior to admission and nothing concerning came back so R2 was admitted on [DATE]. V1 further stated on 3/13/25 V1 was made aware that R2's CHIRP (Criminal History Information Response Process) came back that R2 was an identified offender. V1 stated she went to R2's room to discuss the CHIRP with him and R2 confirmed the report. V1 stated she told him that she needed to make room moves and put R2 in a private room. V1 stated V1 made R2 aware they would have to look for different placement because R2 would not be able to stay at the facility with his conviction. V1 stated R2 asked if there were any local facilities that would take R2 because he wanted to stay in the area. V1 stated she told R2 that individuals convicted as sex offenders usually go to Northern facilities, and they probably could not find a facility in the area. V1 stated R2 stated then just take him back to the (homeless shelter) because R2 did not want to leave the area. V1 stated V1 told R2 that he would have to sign out against medical advice (AMA) if that's what he wanted to do. V1 stated R2 was not able to read or write so they read him the AMA paperwork and R2 signed the papers and then the facility took R2 to the shelter with a bag of food and dropped him off. V1 stated that no referrals to outside agencies were done, and discharge planning was not initiated because R2 signed an AMA paper. V1 stated the facility did not consult the physician or law enforcement prior to discharge. On 3/17/25 at 11:00 AM, R2 stated V1 (Administrator) told R2 that he had to go and that R2 was not able to stay at the facility because of a past conviction. R2 stated V1 asked where R2 wanted to go and then dropped him off at the (homeless shelter) because that's where R2 was before admission to the hospital. R2 stated he cannot read and did not understand what he was signing. R2 stated he told V1 that he could not read the document, but V1 told R2 he had to sign the paper, and then they would take R2 where he wanted to go. R2 further stated he was not given medications or any wound care supplies, so he walked from the homeless shelter to V12 (Nurse Practitioner's) office to try and get some medications. R2 stated V12 admitted R2 to the hospital for wound care where he remains on 3/17/25. On 3/17/25 at 9:55 AM, V4 (Hospital Social Worker) stated V4 was covering the emergency room (ER) on 3/14/25 and V4 received a phone call from V12 (Nurse Practitioner) that R2 showed up at her office with a wound on his foot and needing medications, so V12 sent R2 to the ER (emergency room) because V12 felt R2 couldn't manage at a shelter. V4 stated R2 told V4 he was at a nursing home facility but was told he had to leave. V4 stated R2 told V4 he was interested in going back to the facility. V4 stated V1 (Administrator) told hospital staff R2 signed paperwork to leave AMA but R2 told us he does not read or write, so he did not know what he signed. V4 stated she felt concerned that he is having issues managing his medical care, he is staying at warming center he has no bed there, so he is unable to manage his care. V4 stated R2 takes insulin and needs dressing changes. V4 stated R2 was admitted to hospital on 3/14/25 and is currently still in the hospital for wound management because the hospital has no way to safely discharge R2. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/25 at 3:00 PM, V12 Nurse Practitioner stated that she sent R2 to the emergency roiagnom on [DATE] from her office. V12 stated that R2 is homeless. V12 stated R2 has diabetes and has developed a pressure ulcer on his right great toe from walking around town and wearing a hole in his shoes. R2 is not able to read and has vision issues due to his diabetes. V12 stated R2 also is not able to manage wound care to his foot. V12 stated she referred R2 to the nursing home facility for wound care. V12 stated the facility discharging R2 the way that they did put R2 at risk for developing an infection or losing his toe as R2 is unable to manage his own wound care. V12 stated R2 is currently in the local hospital after walking to her office. V12 stated it's not safe for R2 to be in the homeless shelter as there is no bed for him to sleep on and his toe is going to get worse without medical care. V12 also stated she was not made aware of R2's discharge from the facility until he walked to her office from the homeless shelter.