

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2026
NAME OF PROVIDER OR SUPPLIER  The Haven of Farmer City		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on interview and record review the facility failed to allow a resident to refuse a blood glucose check and failed to provide privacy for blood glucose monitoring and insulin administration for one (R1) of three residents reviewed for resident rights on the sample list of five. Findings include: The undated resident rights policy documents on page three (3) the section titled Your rights to dignity and respect: You have a right to make your own choices. The same document states - Your rights to participate in your own care: You have the right to request, refuse, and/or discontinue any treatment. The Medication Administration policy dated 10/25/2014 documents residents may actively refuse medications. R1's Care Plan dated 04/01/2025 documents an admission date of 04/01/2025. The same document lists R1's diagnoses as Cerebral Infarction, Dysphagia Following Cerebral Infarction, Hypertension, Dementia, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, Anxiety, Chronic Kidney Disease, Stage 3, and Type 2 Diabetes Mellitus with Hyperglycemia. The Facility Incident Report dated 1/22/26 at 08:35AM documents R1 was refusing to have her blood glucose level taken by a nurse. V3 (License Practical Nurse/LPN) approached R1 and took R1's hand and took the blood glucose level while resident was refusing. The report further states Interviews with staff indicated that V3 checked R1's blood glucose level and administered insulin after R1 told V3 she did not want it completed. The report documents V3 stated that V3 was doing what V6 (Power of Attorney/POA) wanted done. On 02/27/2026 at 11:00AM R1 declined interview. On 02/27/2026 at 11:47AM, V7 (Certified Nursing Assistant/CNA) stated on 1/22/26 at breakfast R1 refused the blood glucose level check and insulin. V7 stated V4 (Registered Nurse) left the dining room and V3 (LPN), returned to R1 stating V6 (POA) wants the blood glucose checked and insulin given, then V3 pulled the cover back from R1 and checked the blood glucose level in using blood V3 obtained from R1's finger and left R1's side. V3 then returned with a syringe, pulled the cover back, peeled the sleeve of R1 up and administered the insulin. V7 stated R1 looked at V5 (CNA) and R1 stated my rights were violated. On 02/27/2026 at 12:25PM V2 (Director of Nursing) stated staff should not be performing cares or medical test such as blood glucose monitoring or administering medications if a resident does not want it done. V2 stated nurses should not be checking blood glucose levels or injecting medications such as insulin in the dining room. V2 stated the residents should be provided privacy for medication administration.</p>

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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