

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

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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 06/24/2026
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)		
F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review the facility failed to adequately assess, monitor, document, and respond to a significant change in condition for one of three residents (R5) reviewed for quality of care in the sample list of five. This failure resulted in R5 experiencing a delay in treatment for respiratory symptoms and increased lethargy. Findings Include: The Facility's Change in Resident's Condition or Status Policy revised on August 2008 documents, the Director of Nursing or designee will notify the resident attending physician or On-Call Physician when there has been, a significant change in the resident's physical/emotional/mental condition. This document also states that the Director of Nursing or designee will notify the resident/legal representative when there is a significant change in the resident's physical, mental, or psychosocial status. Notification will be made as soon as possible (within 24hours) of a change occurring in the residents medical/mental condition or status. Record review revealed R5 had diagnoses that included Chronic Respiratory Failure, Acute Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease (COPD) with Acute Exacerbation, Orthopnea, Congestive Heart Failure, Dysphagia, and Hospice Services for Respiratory Failure. R5's care plan indicated R5 elected hospice services on 12/18/25 for Terminal Respiratory Failure and had a Do Not Resuscitate (DNR) order. R5's Nursing Notes document a decline in respiratory status beginning on 6/20/26. On 6/20/26 at 9:37 AM, Nursing Notes document, (R5) continues to cough up stringy, thick green phlegm. The nurse contacted hospice and inquired about obtaining an antibiotic order due to R5's continued respiratory symptoms. On 6/20/26 at 10:20 AM, hospice instructed nursing to administer a nebulizer treatment for phlegm and indicated the hospice physician would be consulted regarding a possible antibiotic order. Nursing Progress note dated 6/22/26 at 1:00 AM, documents R5 was observed repeatedly removing R5's oxygen, R5 was spitting on R5's self and R5's bedding, R5 requested a nebulizer treatment for cough, and complained of ongoing symptoms. Oxygen saturation readings obtained on 6/22/26 were 91% while receiving oxygen via nasal cannula. On 6/23/26 at 9:47 AM, nursing progress note documented R5 was coughing and wheezing, had bilateral bronchial lung sounds, was expectorating a small amount of green sputum, and remained on oxygen at 2 liters per minute via nasal cannula with an oxygen saturation of 96%. The nurse documented hospice was notified and staff were awaiting a return call. On 6/23/26 at 10:05 AM, V4 (Certified Nursing Assistant/CNA) stated on 6/16/26, CNAs (V5 and V6) requested assistance because they were concerned about R5's condition. V4 stated V4 observed R5 in a very lethargic state and performed a sternal rub in an attempt to awaken R5. On 6/23/26 at 11:05 AM, V5 (CNA) stated V5 entered R5's room on 6/16/26 to serve breakfast and noted R5 was not responding to verbal stimuli as R5 normally would. V5 stated, It looked like (R5) wasn't breathing. V5 reported the change in condition to the nurse. V5 stated V7 (Licensed Practical Nurse/LPN) responded that the resident had received morphine at approximately 5:00 AM and instructed staff to elevate the R5's head. V5 stated no vital signs were obtained, and V5 was unaware of any assessment completed by V7 at that time. On 6/23/26 at 11:10 AM, V6 (CNA) stated on 6/16/26 V6 was called to R5's room because something seemed off. V6 stated V6 was unable to awaken R5 and notified V7. V6 stated V6 heard V7 instruct staff to just keep (R5's) head up. V6 further stated R5 had been experiencing a significant cough, and nursing staff were aware of the respiratory symptoms. On 6/23/26 at 1:00 PM, V7 (LPN) stated V5 (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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	and V6 informed V7 that R5 was not responding to verbal stimuli and that this was not R5's baseline. V7 stated V7 instructed staff to reposition R5 and elevate the head of the bed. V7 stated that upon entering the room, R5 appeared drowsy but awakened when spoken to. V7 acknowledged V7 did not notify the physician, did not notify the responsible party, did not complete documentation regarding the episode, and did not document a nursing assessment. V7 stated V7 contacted hospice and was informed a hospice nurse would visit later that day. V7 further stated the R5 had received 0.5 mL (milliliters) of morphine at approximately 5:00 AM and believed this may have contributed to the drowsiness. R5's medical record failed to reveal documentation of a nursing assessment, respiratory assessment, physician notification, responsible party notification, vital signs, oxygen saturation monitoring related to the lethargic episode, or physician orders obtained following the R5's decreased responsiveness on 6/16/26. R5's oxygen saturation records revealed readings of 90% on 6/21/26, 91% on 6/22/26, 92% on 6/23/26 at 7:23 PM and 9:21 PM, and 93% on 6/24/26 at 4:47 AM while receiving oxygen via nasal cannula. On 6/23/26 at 7:32 PM, nursing progress notes in the electronic medical record documented R5 continued to have a productive cough with thick green phlegm. On 6/24/26 at 4:48 AM, nursing documented the resident continued to produce thick green phlegm and had crackles throughout all lung fields. R5 remained on oxygen at 2 liters at this time. R5's medical record documents the Medical Director was not notified until 6/24/26 at 8:48 AM, at which time nursing documented, (R5) continues to have productive cough. Medical Director has been notified of ongoing condition. New order received to start Z-Pak (antibiotic). On 6/24/26 at 9:45 AM, V8 (R5's Power of Attorney), stated V8 did not receive notification of R5's lethargy, decreased responsiveness, oxygen use, or worsening respiratory symptoms. V8 stated the first notification V8 received was on 6/23/26 regarding cough medication and again on 6/24/26 regarding initiation of antibiotic therapy. On 6/24/26 at 10:15 AM, V2 (Regional Nurse Consultant) confirmed that with a resident exhibiting lethargy, decreased responsiveness, oxygen use, and productive green and yellow sputum, nursing staff should have completed and documented a respiratory assessment, obtained vital signs, notified the physician and responsible party, documented the change in condition, and obtained additional orders as clinically indicated.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure accurate accountability and reconciliation of a controlled substance medication for one (R5) of three residents reviewed for medication administration in the sample list of five. Finding include: Electronic Health Record (EHR) and June Medication Administration Record (MAR) reviewed documents R5 had an active physician order for Morphine Sulfate Concentrate Oral Solution 100 mg(milligrams)/5 mL(milliliters) with instructions to administer 0.5 mL by mouth every three hours as needed for pain. The medication had been in use since December 2025 as part of R5's hospice plan of care. On 6/23/26 at 1:00 PM, V3 (Licensed Practical Nurse/LPN) conducted a review of R5's morphine supply and controlled substance records. V3 confirmed the morphine bottle contained approximately 24 mL of medication. V3 further reviewed the facility's narcotic accountability records and determined the Narcotic Check-Out Sheet reflected a remaining balance of 19.5ml. This review of the morphine record documents a discrepancy of approximately 4.5 mL between the amount of morphine documented on the controlled substance accountability record and the amount present in the medication bottle. R5's Electronic Health Record (EHR) documents R5 had received documented administrations of morphine since initiation of the medication in December 2025. Review of administration records from December 2025 through June 22, 2026 documents morphine had been documented as administered 19 times. Based upon the ordered dose of 0.5 mL per administration and a 30 mL bottle, calculations indicated the expected remaining volume did not correspond with the amount documented on the narcotic accountability record. On 6/23/26 at 1:00 PM, V3 stated there should be no discrepancy between the controlled substance log and the actual amount of medication remaining in the bottle. V3 confirmed the narcotic accountability record, and medication supply should reconcile at all times. On 6/24/26 at 10:15 AM, V2 (Regional Nurse Consultant) stated discrepancies involving controlled substances should not occur and require immediate investigation. V2 confirmed the discrepancy identified with R5's morphine supply was not consistent with facility expectations for narcotic accountability. V2 stated the pharmacy has been notified regarding the discrepancy.		