STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000328	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HAVEN OF FARMER CITY	404 BROOKVIEW DRIVE , FARMER CITY, Illinois, 61842

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S0000	Initial Comments Investigation of Facility Reported Incident of August 13, 2025/2593031	S0000		09/02/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)4)5) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 4) All nursing personnel shall assist and encourage	S9999		09/02/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to safely transfer a resident (R1) from the bed to the wheelchair. This failure resulted in R1 sustaining a broken arm requiring emergency evaluation and treatment at the hospital. R1 is one of three residents reviewed for accidents in the sample list of four. This past non-compliance occurred from 8/13/25 to 8/14/25. Findings Include: The facility Safe Lifting and Movement of Residents Policy (revised August 2008) documents the following: In order to protect the safety and well-being of staff and residents, and to promote quality of care, this	S9999		

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S9999	Continued from page 2 facility uses mechanical lifting devices for the lifting and movement of residents. Mechanical lifting devices shall be used for any resident needing a two person assist. Except during emergency situations or unavoidable circumstances, manual lifting is not permitted. R1's Face Sheet dated 8/22/25 documents R1 was admitted to the facility on 7/28/25 and R1's diagnoses include: Presence of Right Artificial Shoulder Joint, Paraplegia, Glaucoma, Osteoarthritis, Rheumatoid Arthritis, Contracture, and Dementia. R1's Comprehensive Assessment dated 8/4/25 documents R1 is moderately cognitively impaired, has bilateral lower extremity impairments, uses a wheelchair (motorized) for mobility, and is dependent on staff for all activities of daily living (ADL) including transfers. R1's Care Plan (current) documents R1 has an ADL self-care performance deficit related to Paraplegia, Rheumatoid Arthritis, Weakness and cognitive decline. Further documents R1 is totally dependent on physical assist of two staff for transferring (bed-to-chair/chair-to-bed, toilet transfers, tub/shower transfers) with use of mechanical lift. R1's Injury of Known Cause Report dated 8/13/25 documents R1 was transferred from R1's bed to wheelchair without the use of a mechanical lift. This same report documents R1 was manually transferred from R1's bed to wheelchair by V5 (Certified Nursing Assistant/CNA) and V6 (CNA) when a "pop" was heard during said transfer and R1 complaining of right shoulder pain. This same report documents R1 would not allow V4 (Licensed Practical Nurse/LPN) to assess for injuries and R1 stating, "it hurts, it hurts, please don't touch it" and R1 sent out to the emergency department for evaluation and treatment. R1's Hospital Record dated 8/13/25 documents R1 was seen for upper arm trauma and R1 had an acute comminuted periprosthetic fracture of the proximal humerus (upper arm). This same record documents R1 received four intravenous (IV) injections of Hydromorphone (narcotic medication used to treat severe pain) and one IV injections of Ketorolac (nonsteroidal anti-inflammatory drug used for the short-term treatment of moderate to moderately severe acute pain) while in the emergency department. V5 (CNA) witness statement dated 8/13/25 documents, "went into [R1's] to assist V6 with [R1]. We sat resident up on side of bed and two person assisted to	S9999		

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S9999	Continued from page 3 wheelchair. As we transferred resident, I heard a loud pop. Immediately alerted nurse to assess." On 8/22/25 at 10:45am, R1 was lying in bed with an immobilizer present on R1's right arm. R1 stated, "I told them I was a mechanical lift. I told them to use a mechanical lift. They dropped me in my chair." R1 stated R1 has no use of lower extremities. On 8/22/25 at 10:52am, R4 (R1's Roommate) stated R4 witnessed the incident. R4 stated staff (V5 and V6 CNAs) did not use a mechanical lift to transfer R1. R4 stated, "they dropped [R1] in [R1's] wheelchair and [R1] hit arm on chair." On 8/22/25 at 11:13am, V6 (CNA) stated on the date of the incident (8/13/25) V6 had mechanical lift sling underneath R1 and the mechanical lift in the room ready to hook R1 up to the mechanical lift. V6 stated, "[V5 CNA] entered the room and said 'we need to get [R1] up. Can you lift?'" V6 stated V6 advised V5 not to lift R1, we have mechanical lift and need to be doing it the proper way. V6 stated V5 already started lifting R1 and V6 then assisted. V6 stated R1 started screaming immediately once in chair. V6 stated V5 ran out of the room at that time and V6 stayed with R1. V6 stated V4 (Licensed Practical Nurse) came into the room to assess R1 and R1 was sent out to the emergency department. V6 stated, "I didn't feel the transfer was proper or correct." V6 stated V6 went by what the CNA communication book stated for resident transfer status. V6 stated V7 (Assistant Director of Nursing/ADON) made a "cheat sheet" for staff to use that listed resident transfer status. On 8/22/25 at 11:35am, V9 (Director of Physical Therapy) stated after a resident is screened for their transfer status, the recommendations are given to the nursing department who updates residents care plan with the appropriate transfer status. V9 stated if a resident is a mechanical lift transfer, the lift should be done with two staff, and the resident should never get transferred any other way especially a stand and pivot. V9 stated there is a reason they are a mechanical lift transfer. V9 confirmed R1 is a two staff assist mechanical lift transfer. On 8/22/25 at 11:47am, V4 (LPN) stated on the date of the incident (8/13/25) V4 was either at the nurses' station or the medication cart when V5 approached claiming V4 need to come to R1's room due to an emergency. V4 stated when V4 entered R1's room, R1 was sitting upright in R1's wheelchair screaming, "it hurts, it hurts, don't touch it." V4 stated V4 asked R1	S9999		

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S9999	Continued from page 4 "what hurts" and R1 stated "my right shoulder." V4 stated R1 would not let V4 assess R1. V4 stated R1 was sent out to the emergency department at that time for evaluation and treatment. V4 stated both V5 and V6 admitted to transferring R1 without a mechanical lift. V4 stated V6 was ready to go with the mechanical lift and the mechanical lift sling was present under R1. V4 stated, "[V5 stated] 'they weren't going to use that (sling), we don't have time.'" V4 stated staff are aware R1 is a mechanical lift transfer and has been since admission to the facility. On 8/22/25 at 11:01am, V7 (ADON) stated nursing staff have transfer competency done upon hire and yearly. V7 stated nursing staff are provided a "cheat sheet" with resident transfer status listed on it and it is documented in the CNA communication binder. Prior to the survey date of 8/22/25, the facility had taken the following actions to correct the non-compliance: 1. On 8/13/25, R1 was sent to the hospital for evaluation and treatment and then returned to the community. 2. On 8/13/25, the Quality Assurance Committee developed a Plan of Correction for the 8/13/25 incident and a Performance Improvement Plan. 3. On 8/13/25, the Director of Nursing provided in-service education to nursing staff on the transfer policy, following individualized transfer procedures, baseline care plans and how to communicate ADL needs of residents. 4. Starting on 8/13/25, the Director of Nursing will audit resident transfers four times a week for four weeks to ensure staff are appropriately transferring. 5. Starting on 8/13/25, the Director of Nursing will audit resident charts for current transfer status in baseline and/or comprehensive care plan four times a week for four weeks. 6. The facility QAPI Committee will continue to monitor the facility's performance to ensure corrective actions to the 8/13/25 incident is effective. 7. Completion date of substantial compliance: 8/14/25. "B"	S9999		

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