(X6) DATE

Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1, , , | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|----------------------------|--|-------------------------------|--------------------------|
| | | | A. BUILDING: | | | |
| | | IL6004824 | B. WING | | 03/24/2025 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| THE HAV | 'EN OF FARMER CIT | Y | OKVIEW DRI CITY, IL 618 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| S 000 | Initial Comments | | S 000 | | | |
| | First Probationary L | icensure Survey | | | | |
| S9999 | Final Observations | | S9999 | | | |
| | Statement of Licens 300.1210b)3) | sure Violations 1 of 4: | | | | |
| | 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. 3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. | | | | | |
| | This REQUIREMEN | NT is not met as evidenced by: | | | | |
| | review the facility fa | on, interview, and record illed to provide appropriate of 1 resident (R3) for catheter t of twelve. | | | | |

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 03/31/25

TITLE

| TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S9999 Continued From page 1 Findings include: On 3/23/25 at 9:50 AM V12 (Certified Nursing Assistant/CNA) provided catheter care for R3. V12 used disposable no rinse wet wipes to clean R3. During the procedure R3 started to have a bowel movement. V12 turn R3 to the left side and V13 (Licensed Practical Nurse/LPN) assisted. V12 started to clean the bowel movement from R3, V12 wiped from the bottom of the buttocks toward the vaginal area. Upon completion of cleaning the bowel movement from R3, V12 then turned R3 to her back. V12 did not complete catheter care by not cleaning the catheter tubing. V12 did not clean the labia again or the urethral meatus to ensure all the bowel movement had been removed. On 3/234/25 at 1:30 PM V12 stated "Yes I was told I went the wrong direction when I was cleaning R3's bottom." The facility policy titled "Catheter Care, Urinary" with the revision date of September 2005 documents in the section titled "Steps in the | <u>Illinois D</u> | Department of Public | Health | | | | |
|---|-------------------|---|---|----------------|--|------|----------|
| THE HAVEN OF FARMER CITY THE HAVEN OF FARMER CITY SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Summary STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 1 Findings include: On 3/23/25 at 9:50 AM V12 (Certified Nursing Assistant/CNA) provided catheter care for R3. V12 used disposable no rinse wet wipes to clean R3. During the procedure R3 started to have a bowel movement. V12 turn R3 to the left side and V13 (Licensed Practical Nurse/LPN) assisted. V12 started to clean the bowel movement from R3, V12 wiped from the bottom of the buttocks toward the vaginal area. Upon completion of cleaning the bowel movement from R3, V12 then turned R3 to her back. V12 did not complete catheter care by not cleaning the catheter tubing. V12 did not clean the labia again or the urethral meatus to ensure all the bowel movement had been removed. On 3/234/25 at 1:30 PM V12 stated "Yes I was told I went the wrong direction when I was cleaning R3's bottom." The facility policy titled "Catheter Care, Urinary" with the revision date of September 2005 documents in the section titled "Steps in the | STATEMEN | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | | | | |
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| THE HAVEN OF FARMER CITY SUMMARY STATEMENT OF DEFICIENCIES DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE | NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
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| Procedure" number 14 "For the female": "Use a washcloth with warm water and soap to cleanse the labia. Use on area of the washcloth with each downward stroke. Next, change the position of the washcloth and cleanse around the urethral meatus. Number 15 "Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward." "B" Statement of Licensure Violations 2 of 4: | | Assistant/CNA) pro V12 used disposab R3. During the probowel movement. and V13 (Licensed assisted. V12 start movement from R3 of the buttocks toward completion of clean R3, V12 then turned complete catheter catheter tubing. V12 or the urethral mean movement had been On 3/234/25 at 1:30 told I went the wrong cleaning R3's botton. The facility policy tit with the revision dad documents in the seprocedure" number washcloth with warm the labia. Use on a downward stroke. If the washcloth and of meatus. Number 15 "Use a water and soap to of from insertion site to outward." | ovided catheter care for R3. Sole no rinse wet wipes to clean ocedure R3 started to have a V12 turn R3 to the left side. Practical Nurse/LPN) ted to clean the bowel R3, V12 wiped from the bottom and the vaginal area. Upon ning the bowel movement from the R3 to her back. V12 did not care by not cleaning the 2 did not clean the labia again attus to ensure all the bowel en removed. O PM V12 stated "Yes I was not direction when I was not man." Itled "Catheter Care, Urinary" atte of September 2005 section titled "Steps in the r 14 "For the female": "Use a material water and soap to cleanse area of the washcloth with each Next, change the position of cleanse around the urethral clean washcloth with warm cleanse and rinse the catheter to approximately four inches | | | | |

Illinois Department of Public Health STATE FORM

6899 If continuation sheet 2 of 12 7TQB11

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|--|---|------|--------------------------|
| | | IL6004824 | B. WING | B. WING | | 4/2025 |
| | PROVIDER OR SUPPLIER | 404 BROC | DRESS, CITY, S DKVIEW DRI CITY, IL 618 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE |
| S9999 | Section 300.1610 M Procedures a) Development of 1) Every facility and procedures for obtaining, dispensir and disposing of drapolicies and proced the Act and this Parfacility. These policies compliance with all local laws. This REQUIREMEN Based on observati interview the facility medications per facility medications per facility medication administered to R12 R12 was one of 13 medication administerial process of the second per facility medication administerial medi | Medication Policies and Medication Policies shall adopt written policies properly and promptly ng, administering, returning, ugs and medications. These ures shall be consistent with t and shall be followed by the cies and procedures shall be in applicable federal, State and NT is not met as evidenced by: on, record review and failed to administer cility policy by not wearing ng capsules to be during medication pass. residents reviewed for | S9999 | DEFICIENCY) | | |
| | medication card and V13 then proceeded of the medication crand placed in puddi | d placed into medication cup. d to pick each capsule up out up and opened each capsule ing with her bare hands. V13 es when working with the | | | | |

Illinois Department of Public Health

STATE FORM 6899 7TQB11 If continuation sheet 3 of 12

| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|--|----------------------------|--|-------------------|--------------------------|
| | | | | | | |
| | | IL6004824 | B. WING | | 03/2 | 4/2025 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| THE HAV | EN OF FARMER CITY | / | OKVIEW DRI CITY, IL 618 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| S9999 | Continued From pa | ge 3 | S9999 | | | |
| | following # 7) "Tablet Crushing/Catablets may require policy. If it is safe to may be crushed or resident has difficult using the following or enteric-coated docrushed; an alternationg-acting capsule administered (without is recommended to exposure to contented to contented to contented to graph of the content of the co | d 10/25/2014 documents the apsule Opening: Crushing a physician's order, per facility o do so, medication tablets capsules emptied out when a ty swallowing or is tube-fed, guidelines. " a. Long acting page forms should not be tive should be sought. Some as can be opened and out crushing contents.) Gloves a protect the nurse from | | | | |
| | Statement of Licens 300.330 300.340c)3)iii) 300.2010a)1) 750.230a)1)2) 750.230c)1)2) 750.230d) 750.230f) | sure Violations 3 of 4: | | | | |
| | is a dietitian; is a graduate of a d program authorized for Education in Nu | efinitions pervisor - a person who: ietetic and nutrition school or I by the Accreditation Council trition and Dietetics, the on and Dietetics, or the | | | | |

Illinois Department of Public Health

STATE FORM 6899 7TQB11 If continuation sheet 4 of 12

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------------------|--|-------------------------------|--------------------------|
| | | IL6004824 | B. WING | | 03/24/2025 | |
| NAME OF F | PROVIDER OR SUPPLIER | | DRESS CITY S | STATE, ZIP CODE | 1 00/2 | -1/2020 |
| | | 404 BROO | OKVIEW DRI | | | |
| THE HAV | EN OF FARMER CITY | FARMER | CITY, IL 618 | 342 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| \$9999 | Department-approvemore hours of class service supervision supervisor in a heal included consultation has successfully consultation as successfully consultation as successfully consultation as successfully consultation and the protection of Professions are certified as a Certified Food Protection Professionals; or has training and expervision and materials are referenced in the supervision and supervision and materials are referenced in the supervision and su | loard of Nutrition; to July 1, 1990, of a red course that provided 90 or sroom instruction in food and has had experience as a sth care institution which on from a dietitian; impleted an Association of vice Professionals approved anager or Certified Food onal course; tified Dietary Manager or ection Professional by the tion & Foodservice perience in food service inagement in a military service at to the programs in the rth paragraph of this definition. Corporated and Referenced atutes and State regulations is Part: bis rules ode (77 III. Adm. Code 750) Director of Food Services in, qualified by training and the responsible for the total food es of the facility. This person ininimum of 40 hours each | S9999 | | | |
| | Section 750.230 Fo | od Handlers Training | | | | |

Illinois Department of Public Health

STATE FORM 6899 7TQB11 If continuation sheet 5 of 12

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|----------------------------|--|-------------------------------|--------------------------|
| | | | A. BUILDING: | | | |
| | | IL6004824 | B. WING | | 03/2 | 4/2025 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| THE HAV | EN OF FARMER CIT | Υ | OKVIEW DRI CITY, IL 618 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| \$9999 | certificate, shall red food handling princ 750.210, within 30 a 2) The regulation considered to be an State, and local reg 3.05 of the Food Handlers Establishment That 1) All food hand service establishment other than someone sanitation manager obtain training in be as outlined in Section (e) of the Food Enforcement Act) 2) New employ within 30 days after d) Food Handlers All food handlers en licensed day care his schools, and long-totheir training every of the Food Handling Enforcement Act) f) Proof of Training Proof that a food has be available upon ror local health depain an electronic form | cood protection manager seive or obtain training in basic iples, as outlined in Section days after employment. On of food handler training is a exclusive function of the gulation is prohibited. (Section andling Regulation Employed By a Food Service at Is Not a Restaurant dilers employed by a food ent that is not a restaurant, we holding a food service of certificate, shall receive or asic food handling principles, on 750.210. (Sections 3.05(a) Handling Regulation and of the property of th | \$9999 | | | |

6899

Illinois Department of Public Health STATE FORM

PRINTED: 04/16/2025 FORM APPROVED

Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---|--|-------|-------------------------------|--|
| | | IL6004824 | B. WING | | 03/2 | 4/2025 | |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | | |
| THE HAV | /EN OF FARMER CIT | V | OKVIEW DRI CITY, IL 618 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE | |
| S9999 | This REQUIREMENT Based on observation review, facility dietarequired minimum of facility also failed to Director of Food and failure has the poteresiding in the facility also failed to Director of Food and failure has the poteresiding in the facility on the facility operations in the facility of the full-time of the full-time of the facility of the facility on the facility one days of the facility of the facil | NT is not met as evidenced by: Ion, interview, and record ary staff failed to complete training for food handlers. The beenploy a clinically qualified and Nutrition Services. This antial to affect all 48 residents ty. Interview, and record ary staff failed to complete training for food handlers. The beenploy a clinically qualified and affect all 48 residents ty. Interview, and record and affect all 48 residents ty. Interview, and record and anger (all 48 residents ty. Interview, and record and affect all 48 residents ty. Interview, and record and anger affect all 48 residents ty. Interview, and record and anger affect all 48 residents ty. Interview, and record and anger affect all 48 residents ty. Interview, and record and anger affect all 48 residents ty. Interview, and record and anger affect all 48 residents ty. Interview, and record and anger affect all 48 residents the same residents and anger a | S9999 | | | | |

Illinois Department of Public Health

STATE FORM 6899 7TQB11 If continuation sheet 7 of 12

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|---|--|----------------------------|--|-------------------|--------------------------|
| | | IL6004824 | B. WING | | 03/2 | 4/2025 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| THE HAV | /EN OF FARMER CIT | V | OKVIEW DRI CITY, IL 618 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| S9999 | more hours of class service supervision supervisor in a hea included consultation has successfully consultation & Foodser Certified Dietary Ma Protection Professi is certified as a Cercertified Food Protection of Nutrection Professionals; or has training and exsupervision and manager in the kitter of the facility Assess the facility Assess the facility resource competent support day includes a Diet qualified nutrition pas the facility Dieta documents the facility Dieta documents the facility Resource competent support day includes a Diet qualified nutrition pas the facility Dieta documents the facility Dieta documents the facility Resource competent support day includes a Diet qualified nutrition pas the facility Dieta documents the facility Dieta documents the facility Resource facility kitchen. and preparing resic kitchen. V4 reporter Food Handler training the facility training the facility Resource food Handler training food for the facility Resource food Handler training food for the facility Resource food Handler training food for the facility Resource food for the food food food food food food food foo | sroom instruction in food and has had experience as a alth care institution which on from a dietitian; ampleted an Association of rvice Professionals approved anager or Certified Food analy course; attified Dietary Manager or ection Professional by the aition & Foodservice perience in food service anagement in a military service ant to the programs in the arth paragraph of this definition. 105AM, V4 reported the food hen is available for all aility to eat. 105AM, V4 reported the food hen is available for all aility to eat. 105AM, V4 reported the food hen is available for all aility to eat. 105AM, V4 reported the food hen is available for all aility to eat. 105AM, V4 reported the food hen is available for all aility to eat. 105AM, V4 reported the food hen is available for all aility to eat. | \$9999 | | | |

Illinois Department of Public Health STATE FORM

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|---|---|--------|--------------------------|
| | | IL6004824 | B. WING | | 03/2 | 24/2025 |
| | PROVIDER OR SUPPLIER | 404 BROC | DRESS, CITY, S DKVIEW DRI' CITY, IL 618 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETE DATE |
| S9999 | On 3/22/2025 at 2:4 is the only dietary s completed the Food The facility dietary s documents V5 (Die (Dietary Aide), V8 (have all been emple longer than 30 days The facility Resider documents 48 residents and comments 48 residents and 300.2050c)1)A)B)C 300.2050c)1)A)B)C 300.2090a) Section 300.2050 N Each resident shall resident's needs and The facility shall use and purchase food following Recommente Food and Nutrit Research Council, Sciences. c) Vegetable and F servings of fruits or 1) A serving of fruits or 2) A serving confrozen fruit or vegetable and F servings of fruits or 3/4 cup for C) One cure 2) The five or A) Sources Sources | 43PM, V4 reported V16 (Cook) taff member who has d Handler training. Staff roster (undated) tary Aide), V6 (Cook), V7 Cook), and V11 (Dietary Aide) byed in the facility kitchen is. At List Report (3/17/2025) dents reside in the facility. Meal Planning be served food to meet the lad to meet physician's orders. The this Section to plan menus in accordance with the lended Dietary Allowances of ion Board of the National National Academy of Fruit Group: Five or more vegetables. Onsists of: hopped raw, cooked, canned | \$9999 | | | |

Illinois Department of Public Health

STATE FORM 6899 7TQB11 If continuation sheet 9 of 12

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING: _ | CONSTRUCTION | | SURVEY PLETED |
|--|---|--|---|--------------------------------|--------------------------|
| | IL6004824 | B. WING | | 03/ | 24/2025 |
| NAME OF PROVIDER OR SUPPLIER THE HAVEN OF FARMER CITY | 404 BRO | ORESS, CITY, STOCKVIEW DRIV CITY, IL 6184 | Æ | | |
| PREFIX (EACH DEFICIENCY N | EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| ii) Two so vitamin C. This may land shall contain a to vitamin C. B) One serve vitamin A at least three least 1000 micrograme vitamin A. C) Other fruit potatoes, that may be portions. Section 300.2090 For a) Foods shall be premethods that will comenhance their flavor a be prepared according and a file of such received the cook's use. This REQUIREMENT Based on observation review, the facility fair required daily serving Vegetable and Fruit Confacility Dietician. The standardized recipes items. This failure heresidents (R7-R11) or diets in the sample list Findings include: On 3/22/2025 at 9:08 | g at least 60 mg of vitamin servings of a fair source of be more than one food item otal of at least 65 mg of ving of a good source of see times a week supplying at ms retinol equivalent (RE) of ts and vegetables, including e served in 1/3 cup or larger of Preparation and Service repared by appropriate and appearance. They shall ng to standardized recipes sipes shall be available for a time to serve the minimum of foods from the Group as planned by the facility failed to affect five of five reviewed for pureed | \$9999 | | | |

Illinois Department of Public Health

STATE FORM 6899 7TQB11 If continuation sheet 10 of 12

| NAME OF PROVIDER OR SUPPLIER THE HAVEN OF FARMER CITY STREET ADDRESS, CITY, STATE, ZIP CODE 404 BROOKVIEW DRIVE FARMER CITY, IL 61842 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX B. WING O3/24/2025 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE O3/24/2025 | | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | | SURVEY PLETED |
|--|-----------|---|---|---------|---|-----------|--------------------------|
| NAME OF PROVIDER OR SUPPLIER THE HAVEN OF FARMER CITY STREET ADDRESS, CITY, STATE, ZIP CODE 404 BROOKVIEW DRIVE FARMER CITY, IL 61842 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL | | | | | | | |
| THE HAVEN OF FARMER CITY 404 BROOKVIEW DRIVE FARMER CITY, IL 61842 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL | | | IL6004824 | B. WING | | 03/2 | 24/2025 |
| THE HAVEN OF FARMER CITY FARMER CITY, IL 61842 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL | NAME OF F | PROVIDER OR SUPPLIER | | | | | |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL | THE HAV | EN OF FARMER CIT | Y | | | | |
| TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | PRÉFIX | (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE | SHOULD BE | (X5) COMPLETE DATE |
| facility kitchen. V4 denied using any recipes to guide preparation of pureed food items. On 3/22/2025 at 11:36AM, V4 (Dietary Manager) and V5 (Dietary Aide) were preparing resident lunch trays in the facility kitchen. No puree cooked cabbage was present on the service line and no substitute of similar nutritive value was present in lieu of the cooked cabbage. V4 reported pureed food servings are placed into a food processor and liquid water or broth are added as-needed but the volume of water added is not measured or recorded. On 3/23/2025 at 11:37AM, V4 was preparing pureed food items in the kitchen. V4 placed 6 cooked chicken breasts into the food processor and added an unmeasured quantity of water into the processor and blended the mixture until the mixture appeared smooth. V4 continued making puree food items with a second food processor and placed slightly over six servings of cake into the processor and added an unmeasured quantity of milk into the processor and blended the cake until smooth in texture. V4 did not measure the final as-prepared food volumes of the chicken or cake to determine what size food scoop to use when serving residents who receive a puree diet. On 3/22/2025 at the noon meal service, no residents who received a pureed diet during the noon meal service were served pureed cabbage or any substitute in place of the cabbage. The facility menu for 3/22/2025 documents dietary staff should have served residents who receive a puree diet on 3/22/2025. The facility Meal Service Report (3/22/2025) | \$9999 | facility kitchen. V4 guide preparation of On 3/22/2025 at 11 and V5 (Dietary Aid lunch trays in the facooked cabbage wand no substitute opresent in lieu of the reported pureed food processor and added as-needed be is not measured or On 3/23/2025 at 11 pureed food items is cooked chicken breand added an unmethe processor and I mixture appeared spuree food items wand placed slightly the processor and of milk into the procuntil smooth in text final as-prepared for cake to determine when serving reside On 3/22/2025 at the residents who recension meal service or any substitute in The facility menu for dietary staff should receive a puree diecabbage during the 3/22/2025. | denied using any recipes to of pureed food items. :36AM, V4 (Dietary Manager) de) were preparing resident acility kitchen. No puree as present on the service line of similar nutritive value was de cooked cabbage. V4 and servings are placed into a deliquid water or broth are put the volume of water added recorded. :37AM, V4 was preparing in the kitchen. V4 placed 6 deasts into the food processor deasured quantity of water into added the mixture until the smooth. V4 continued making with a second food processor over six servings of cake into added an unmeasured quantity dessor and blended the cake ure. V4 did not measure the bod volumes of the chicken or what size food scoop to use ents who receive a puree diet. The place of the cabbage place of the cabbage. Our 3/22/2025 documents have served residents who det 1/3 cup of pureed sauteed a lunch meal service on | S9999 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE COMF | (X3) DATE SURVEY COMPLETED | |
|--|----------------------|--|--|---|-------------------------------|--------------------------|
| | | IL6004824 | B. WING | | 03/2 | 24/2025 |
| | PROVIDER OR SUPPLIER | , 404 BROO | DRESS, CITY, S DKVIEW DRI CITY, IL 618 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE |
| S9999 | · | ge 11 R9, R10, and R11 all receive | S9999 | | | |

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