STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056002	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR HAVENS SENIOR LIVING	1790 SOUTH FAIRVIEW AVENUE , DECATUR, Illinois, 62521

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S0000	Initial Comments Complaint Investigation: 2566607/2564698, 2566868/2571665, 2567034/2576450	S0000		08/14/2025
S9999	Final Observations Statement Of Licensure Violation: 300.610a) 300.1210a) 300.1210b) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's	S9999		08/14/2025

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

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S9999	Continued from page 1 guardian or representative, as applicable 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 resid These regulations were not met as evidenced by: Example 1 Based on interview and record review, the facility failed to ensure physician orders were accurately transcribed and implemented for one (R7) of one resident reviewed for blood glucose monitoring in a sample list of nine residents. These failures resulted in R7 being hospitalized for Diabetic Ketoacidosis. Findings include: On 8/4/25 at 2:00 pm, R7's care plan dated 7/7/25 documents an admission date of 7/4/25 with the diagnosis of Heart Failure and Type 2 Diabetes Mellitus with Hyperglycemia. R7 admitted to the facility for therapy with the discharge plan to return home. R7's Discharge Plan dated 7/4/2025 at 8:59:32 documents on page three (3) under section Discharge Instructions: * Blood Glucose monitoring - check blood sugar before meals and at bedtime. On 8/4/25 at 2:00pm, R7 Record review documents a physician order for Insulin Glargine Subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Inject 10 units subcutaneously one time a day related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65) -Start Date 7/05/2025 at 0900. On 8/4/25 at 2:00pm, R7 Record review does not contain a physician order for blood glucose monitoring- check blood sugar before meals and at bedtime. On 8/4/25 at 2:22pm, R7 Record review of nursing progress notes documents on 7/22/25 at 06:17am, V21 LPN (Licensed Practical Nurse) documents R7 exhibited symptoms of altered mental status with a blood glucose over 500mg/dl (milligrams per deciliter). On 8/4/25 at 2:22pm, the next progress note entered in the R7's Record review of nursing progress notes	S9999		

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S9999	Continued from page 2 documents V22 LPN, called the local hospital in regard to the condition of R7 and was told R7 was admitted to the hospital with Diabetic Ketoacidosis and Urinary Tract Infection. On 8/4/25 at 2:25pm, hospital record review documents R7 arrived at the local hospital emergency room on 7/22/2025 at 6:31am. On 8/4/25 at 2:25pm, Record review of hospital notes V23 Registered Nurse (RN), documents Nursing home reports altered mental status. That patient was sweating and clammy with a temp of 102.4 and R7 blood glucose was over 600. Laboratory results obtained in the hospital document a blood sugar of 738mg/dl. On 8/5/25 at 10:27am, V16 Primary Care Physician stated R7's elevated blood glucose level on 7/22/25 at 06:00am was secondary to infection and likely would have been elevated at bedtime. On 8/5/25 at 1:25pm, V21 LPN stated on the morning of 7/22/25 at 06:00am, V21 went into R7's room to do the blood glucose and R7 was not acting herself. V21 stated she proceeded to do the blood glucose, and it did not register on the meter, it stated high. V21 stated V21 proceeded to send R7 to the emergency room. V21 stated R7's blood glucose readings were elevated at times. On 8/11/25 at 10:22am, V3 DON and V4 ADON, confirm R7's transfer physician orders dated 7/4/25 document Blood Glucose monitoring - check blood sugar before meals and at bedtime. V3 DON and V4 ADON confirm R7's medical record physician orders section does not contain the physician order for Blood Glucose monitoring - check blood sugar before meals and at bedtime. Example 2 Based on interview and record review the facility failed to notify the primary care physician of a change in condition when the onset of multiple episodes of diarrhea began for one (R7) of three residents reviewed for death on the sample list of nine.1 This failure resulted in R7 having multiple episodes of untreated diarrhea for eight consecutive days. Findings Include: On 8/11/25 at 11:30 AM, Record review of Notification of Resident Change in Condition Policy, Undated, states: It is the policy of this facility to promptly notify the resident, their legal representative and attending physician of changes in the resident's health	S9999		

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S9999	Continued from page 3 condition. The same document states under Standards: 2. The licensed nurse is to use professional judgment in determining changes in condition based on assessment and findings or signs and symptoms of change which could lead to deterioration if not treated. 3. Clinical change in condition is determined by resident visualization, medical record review, clinical assessment findings and care plan review. Review of high-risk clinical issue such as skin breakdown, falls, weight loss, dehydration and others are conducted on a daily basis. 7. Changes in the resident's condition will be communicated to the direct care staff by verbal shift-to-shift report, revision in resident assignments and by use of the 24 hour written shift report. On 8/4/25 at 2:00 pm, R7's care plan dated 7/7/25 documents an admission date of 7/4/25 with the diagnosis of Heart Failure and Type 2 Diabetes Mellitus with Hyperglycemia. R7 admitted to the facility for therapy with the discharge plan to return home. This care plan documents R7 is incontinent. This care plan does not document that R7 has a history of diarrhea. R7's Bowel Movement and Continence Look Back record for the last 30 (days) documents by nursing staff that R7 was incontinent of bowels and had loose/diarrhea on 7/14/25 at 8:51 pm and 11:25 pm, on 7/16/25 at 7:45 am and 11:12 pm, on 7/18/25 at 10:38 am, and on 7/19/25 at 10:59 pm. R7 Bowel Movements and Continence Look Back record is incomplete from 7/20/25 thru 7/22/25. On 8/5/25 at 1:32 pm, V19 Certified Nursing Assistant stated V19 cared for R7 most nights V19 worked. V19 stated R7 was incontinent of her bowels and had loose/diarrhea stools at least every other night. V19 stated V19 documented in the medical record the loose/diarrhea stools and V19 stated V19 informed the nurse on duty when R7 had loose stools. R7's Nurse's Note dated 7/21/25 at 5:30 pm, written by V22 Licensed Practical Nurse documents R7 had three (3) episodes of diarrhea after returning from dialysis. On 8/6/25 at 10:36 am, V22 stated R7 had three loose/diarrhea stools on 7/21/25 after returning from the dialysis clinic at 5:15 pm. V22 stated V22 filled out an SBAR (Situation, Background, Assessment, and Recommendation form) and faxed it to the physician (V16) at 5:30 pm due to a concern for C Diff (Clostridium Difficile) and requested an antidiarrheal medication. V22 stated V22 does not recall if R7 had loose/diarrhea stools on other days. V22 stated she did	S9999		

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S9999	Continued from page 4 not provide R7 with antidiarrheal medication due to no order. R7's medical record does not document that R7's physician was notified of R7's diarrhea or that R7 was treated for diarrhea which started on 7/14/25. On 8/5/25 at 1:25 pm, V21 stated V21 took care of R7. V21 stated R7 was incontinent of bowel and bladder at nighttime. V21 stated V21 recalled, "R7 having loose/diarrhea stools once or twice for sure". V21 stated on the morning of 7/22/25 at 6:00 am, V21 went into R7's room to do the blood glucose and R7 was not acting herself. V21 stated she proceeded to do the blood glucose, and it did not register on the meter, it stated high. V21 stated V21 proceeded to send R7 to the emergency room. V21 stated R7 blood glucose reading were elevated at times. V21 doesn't recall being informed by staff that R7 was having frequent loose/diarrhea stools. R7's Laboratory Report documents a stool sample collected on 7/22/25 at 10:46 PM was positive for Clostridium Difficile (C-Diff). On 8/5/25 at 10:27am, V16 Primary Care Physician stated that V16 was not notified of R7 having multiple loose/diarrhea stools documented as starting on 7/14/25 in the medical record. V16 stated V16 expects the nursing staff to notify him when a resident is having multiple and frequent loose/diarrhea stools. On 8/6/25 at 11:18am, V26 registered nurse stated V26 was the nurse on duty 7/14/25 from 11:00pm to 06:00am. V26 stated she does not recall being told by the CNA (Certified Nursing Assistant) that R7 had a loose/diarrhea stool. On 8/11/25 at 09:54am, V28 License Practical Nurse V28 stated the expectation is that the CNA will inform the nurse when a resident is having loose stools, and the nurse will inform the physician. V28 stated that the nurses have access to bowel and bladder charting and can look to see how the residents are being charted on. V28 confirms the documentation of loose/diarrhea stools in the medical record of R7. V28 confirmed V22 should have called the physician on the telephone after completing the SBAR. V28 confirms there is no SBAR (Situation, Background, Assessment, and Recommendation form) completed by V22 in the medical record. Example 3 Based on interview and record review, the facility	S9999		

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S9999	Continued from page 5 failed to remove a washcloth from the adult incontinence brief after cares were provided. This failure resulted in R2 experiencing a foul odor causing R2 to feel humiliated and embarrassed while in public. R2 was one of three residents reviewed for quality of care on a sample list of nine. Findings include: On 08/04/2025 at 2:30PM, Employee handbook dated revised Oct 1, 2019, documents on page 3: We count on you, our employees, to focus on the provision of quality care and excellent services for our residents and to do so with a high level of dignity, compassion, and responsiveness to their physical, medical, and emotional needs. R2's Clinical Census, undated, documents an original admission date of 8/31/23. Minimum Data Set completed on July 23, 2025, document a Brief Interview for Mental Status (BIMS) score of 12 of 15. A score of 12 indicates R2 has moderate cognitive impairment. R2's Care plan dated 09/01/2023 documents diagnosis of: End Stage Renal Disease, Essential (Primary) Hypertension, Hereditary and Idiopathic Neuropathy, Paraplegia. The same care plan documents: Usual ADL (Activities of Daily Living) Performance: R2 is independent for eating with set up help. Max A (maximum assistance) of one to two is needed for personal hygiene, dressing, toileting & bed mobility, dependent with transfers with a total body mechanical lift of two. On 07/24/25 at 10:30am, R2 stated on 07/12/25 R2 activated his call light at 07:00am to get help from the nursing staff to get cleaned up and dressed for dialysis. R2 stated the transportation bus picks him up at 08:00am for dialysis. R2 stated two (2) certified nursing assistants (CNA) came into the room at 07:50am to get R2 ready for dialysis and were very hurried in trying to get him ready for the bus. R2 stated R2 made the bus and went to dialysis, upon completion on his dialysis treatment R2 stated he smelled something on himself and was now upset because he does not like being dirty or smelling. R2 stated that he asked the dialysis nurse if she smelled something, she replied yes, she does. R2 stated he asked the bus driver if he smelled something, R12 stated the bus driver stated he did when the bus driver leaned over to secure the wheelchair. R2 stated he was humiliated and did not talk the ride from the dialysis center to the facility.	S9999		

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S9999	Continued from page 6 R2 stated that upon arriving back to the facility he asked the staff to lay him down and help him get cleaned up, to which the second shift CNAs did. Upon opening up the incontinence brief, the CNA behind him exclaimed “Oh my God” and held up a washcloth she stated was from inside the brief and causing the odor. R2 stated he was humiliated at the smell and could not believe someone left a washcloth in his brief. On 7/24/25 at 12:00 pm, V8 LPN (License Practical Nurse), stated that she was the nurse on duty on 7/12/25 and sometime in the afternoon a CNA reported to her that when providing cares to R2 and the CNA removed the brief there was a washcloth in the brief. V8 stated that R2 was very mad and upset and refused an assessment of the area and wanted to be left alone. On 07/24/25 at 12:35pm, V9 CNA stated she was told there was a washcloth in the incontinence brief, but unsure how that happened. On 07/24/25 at 1:38pm, V10 CNA stated she assisted V9 CNA in getting R2 ready for dialysis but R2 was very upset and yelling at staff. V10 stated she was told there was a towel in the brief but does not know how it got there. On 07/24/25 at 1:48pm, V11 CNA stated when R2 returned from dialysis R2 requested help in getting cleaned up due to having a smell from his body. V11 stated R2 was transferred to the bed via the total mechanical body lift, rolled over and removed the brief and discovered a wet washcloth in the intergluteal cleft, (skin fold between the buttocks). V11 stated R2 was very upset at the smell and that a washcloth was left inside the brief. V11 stated R2 requested to be left alone once cares were completed. (A)	S9999		