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 12/10/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Annual Certification Survey Complaint Investigation: 25611715/2682470 2561164/2679880	S0000		12/29/2025
S9999	Final Observations Statement Of Licensure Violations: (1 of 3) 300.610a) 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 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	S9999		12/29/2025

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

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 12/10/2025

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S9999	Continued from page 1 personal care needs of the resident. These regulations were not met as evidenced by: Based on Observation, Interview and Record Review the facility failed to protect the dignity and psychosocial wellbeing for two residents (R26, R69) reviewed for dignity out of a sample list of 49. This failure resulted in psychosocial harm for R26, R69 with feelings of disrespect. Findings Include: 1.) The Minimum Data Set dated 11/30/2025 documents that Resident R26 is severely cognitively impaired, requires maximum assistance with activities of daily living, and has a diagnosis of dementia. On 12/07/2025 at 8:30 AM, R26 was observed lying in bed on the left side, with the right side of the head positioned partially on a pillow and partially against the wall. The wall next to the bed, which was flush with the west wall, had noticeable dried brown hand wipes on the white surface. On 12/07/2025 at 8:51 AM, V2 (Director of Nursing) observed R26 and stated that the substance on the wall was feces, and that the resident's head was lying in the feces. On 12/08/2025 at 2:31 PM, V11 (R26's Power of Attorney) stated that R26 was in the facility for rehabilitation. V11 stated that no one had contacted them regarding R26's head lying in feces and further stated, "My mom wouldn't have appreciated her head lying in poop." 2.) The Minimum Data Set dated 09/25/2025 documents that Resident R69 is cognitively intact and requires maximum assistance with activities of daily living. On 12/07/2025 at 8:27 AM, R69 stated that when needing to use the restroom, the call light system is activated; however, at times it has taken over an hour for staff to respond. R69 stated this delay resulted in urinary incontinence and made the resident feel disrespected. On 12/07/2025 at 11:40 AM, V15, Licensed Practical Nurse, stated that all call lights should be answered as quickly as possible and that a response time of over an hour is not acceptable. V15 further stated that R69 is alert and would know when restroom assistance is needed.	S9999		

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S9999	Continued from page 2 The facility policy, revised April 2007, documents that the facility will make every effort to assist each resident in exercising their rights to ensure that residents are always treated with respect, kindness, and dignity. (B) (2 of 3) 300.610a) 30012.10b) 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. 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	S9999		

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S9999	Continued from page 3 shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These regulations were not met as evidenced by: Based on observation, interview, and record review the facility failed to properly transfer a resident (R2) for one of two residents reviewed for accidents in the sample list of 49. This failure resulted in bruising and pain to R2's right leg. Findings include: The facility's Safe Lifting and Movements of Residents policy, dated August 2008, documents that resident transfer needs will be assessed on an ongoing basis and that transfer status will be documented in the care plan. On 12/07/2025 at 10:30 AM, R2 stated that the previous night staff struck the back of her right leg against the bed frame while using a sit-to-stand lift. R2 stated that management was aware and had looked at her leg that morning. R2 grimaced when moving her right leg and stated that the incident caused pain to her right leg. On 12/09/2025 at 1:10 PM, V38 and V39, Certified Nursing Assistants (CNAs), used a sit-to-stand lift to transfer R2 onto the toilet in the 200-unit shower room. R2 held on with both hands, bore weight with a bent posture, and the chest strap remained loose. R2 did not fully stand, and her knees remained bent. R2 had lymphedema (swelling) in both legs. V39 stated that R2 uses a full mechanical lift for transfers in and out of bed and a sit-to-stand lift for toilet transfers, which was approved by therapy. At 1:28 PM, V38 and V39 transferred R2 from the toilet back to her wheelchair using the sit-to-stand lift. R2 was observed to have a baseball-sized blue/purple bruise on the back of her right calf/knee. R2 stated, "See what they did to me. They banged my leg on the bed. It hurts." V39 asked R2 if she had reported this to the nurse, and R2 stated that nurse management was aware. R2 exhibited visible facial grimacing, moaning, and complaints of pain during the transfers. V38 and V39 transported R2 to her room and transferred her into bed using a full mechanical lift. V39 stated that staff do not tighten the chest strap on the sit-to-stand lift because R2 refuses and does not like	S9999		

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S9999	Continued from page 4 it, and that R2 usually stands “better than that.” A sign posted on R2’s wall near the bed instructed staff to use a full mechanical lift for bed transfers and a sit-to-stand lift for toilet transfers. At 1:44 PM, R2 stated that some staff use the full mechanical lift and some use the sit-to-stand lift to transfer her into bed. R2 stated that she did not have right leg pain prior to the incident that caused the bruise. R2’s Minimum Data Set dated 11/17/2025 documents that R2 is cognitively intact and dependent on staff for chair, bed, and toilet transfers. R2’s care plan documents a diagnosis of lymphedema and was revised on 11/18/2025 to reflect transfer status as a mechanical sit-to-stand lift for toileting in the shower room and a full mechanical lift to and from bed. This information is also reflected in CNA task lists and charting. R2’s nursing note dated 12/07/2025 at 6:35 AM documents bruising and hardening to the back of the right leg near the knee area, with complaints of slight pain. Nursing notes and the December 2025 Medication Administration Record document that Tramadol 50 mg was administered on 12/07/2025 at 8:30 AM for complaints of right leg pain rated 5 out of 10, with follow-up pain rated at 4. On 12/09/2025 at 2:40 PM, V25, CNA, stated that she worked on R2’s hallway on Saturday night (12/06/2025) and that a sit-to-stand lift was used to transfer R2 into bed; however, V25 stated she was not the individual who “rammed” R2’s leg into the bed frame. V25 stated that V26 was the other CNA assisting with R2’s transfers that night and that V26 operated the lift. V25 stated that she did not realize anything had occurred until R2 asked V25 and V26 to look at her leg after the transfer because R2 felt something on the back of her leg. V25 stated she had recently started working on that hallway and had asked how R2 transferred; she was told R2 used a sit-to-stand lift. V25 stated it was not until Sunday that she learned R2 was supposed to use a full mechanical lift, after V2, Director of Nursing, spoke to her regarding R2’s bruising. On 12/09/2025 at 2:49 PM, V2 stated that R2’s bruise occurred during a transfer when R2 was positioned too close to the bed. V10, Licensed Practical Nurse/Wound Nurse, stated that she investigated R2’s bruising and interviewed R2 and the CNAs. V10 stated that R2 reported the CNAs used a sit-to-stand lift to transfer	S9999		

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S9999	Continued from page 5 her into bed and pushed too hard on the lift, causing R2's leg to strike the metal bed frame. V10 interviewed V25 and V26 and confirmed that V26 operated the lift with assistance from V25. V10 stated that both CNAs were educated on proper transfer techniques, instructed to use caution during transfers, and issued verbal warnings for improper transfer, as R2 requires a full mechanical lift for bed transfers. Employee Disciplinary Reports dated 12/07/2025 document that V25 and V26 received verbal warnings for improper transfer, specifically using a sit-to-stand lift instead of a full mechanical lift, resulting in the resident sustaining a bruise to the leg after contact with the metal bed frame. (B) (3 of 3) 300.1210a) 300.1210b) 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 guardian or representative, as applicable. (Section 3-202.2a of the Act) 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.	S9999		

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S9999	Continued from page 6 These regulations were not met as evidenced by: Based on observation, interview, and record review the facility failed to provide hygienic catheter care, monitor urinary catheter output, and timely treat symptoms of urinary tract infection for three of four residents (R2, R5, R49) reviewed for urinary catheters/urinary tract infections (UTIs) in the sample list of 49. These failures resulted in R49 developing urinary retention, UTI, urosepsis, acute kidney injury, and hydronephrosis that required hospitalization and urinary stent placement. Findings include: 1.) On 12/07/2025 at 8:13 AM, R49 was observed lying in bed with a urinary catheter drainage bag attached to the bed frame. A sign near R49's doorway indicated that R49 was on Enhanced Barrier Precautions (EBP), requiring gown and gloves for high-contact care activities, including catheter care and transfers. A container with personal protective equipment (PPE) was present on R49's door. At 1:04 PM, R49 stated he had had the catheter for a long time and that it was last changed approximately one month earlier while hospitalized for a UTI. R49 stated that staff do not empty the catheter as often as they should and that some staff provide better catheter care and cleaning than others. V32, R49's spouse, stated that staff should have identified changes in R49's urine. V32 further stated that she received a phone call the night R49 was sent to the hospital with red-tinged urine and that R49 required placement of urinary stents. On 12/08/2025 at 10:55 AM, V5 and V7, Certified Nursing Assistants (CNAs), entered R49's room with a full mechanical lift while R49 was seated in his wheelchair. V5 and V7 did not don gowns upon entering the room. At 11:04 AM, R49 was in bed, and V5, V6, and V7 were present in the room without gowns. All three staff members washed their hands, applied gloves, and assisted with catheter care without wearing gowns. V7 cleansed and dried R49's inner thighs and penis, making contact with the urinary catheter multiple times. V7 cleansed the catheter tubing near the insertion site but did not clean the length of the tubing as required. R49's Minimum Data Set (MDS), dated 10/18/2025, documents that R49 scored in the higher range for moderate cognitive impairment and has a urinary	S9999		

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S9999	Continued from page 7 catheter. R49's active care plan includes a problem dated 10/24/2024 for urinary catheter use, with interventions to change the catheter as ordered and to monitor, record, and report signs and symptoms of UTI, including no urine output. R49's physician progress note dated 05/24/2025, recorded by V35, Urologist, documents that R49 was admitted to the hospital with an indwelling urinary catheter, severe UTI, and sepsis. The note documents that R49's catheter was changed and that R49 requires monthly catheter changes, which could be performed at the long-term care facility or in V35's office. This plan was discussed with R49 and his family. A urology progress note dated 10/03/2025 documents continuation of the indwelling catheter with monthly changes. R49's December 2025 Medication Administration Record (MAR) documents an order to change the urinary catheter as needed as of 07/08/2025. R49's June 2025 MAR documents an order to change the catheter every 30 days. There is no documentation in R49's medical record that the catheter was changed after 06/23/2025 until 11/16/2025, when R49 was hospitalized. There is also no documentation that urinary catheter output was routinely measured or monitored during this period prior to 12/04/2025. A nursing note dated 11/16/2025 at 12:47 PM documents that R49 had no urine output, low blood pressure and pulse, difficulty speaking and swallowing, altered mental status, lethargy, and labored breathing. R49's temperature was 99.1°F, pulse 29 beats per minute, respirations 18 per minute, and blood pressure 102/57. The physician was notified on 11/16/2025 at 6:51 AM. R49's Hospital History and Physical dated 11/16/2025 documents admission for urosepsis, septic shock, catheter-associated UTI, acute kidney injury, bilateral hydronephrosis, and bilateral renal cysts. R49's creatinine was 3.9 on arrival, compared to a baseline of approximately 0.8. R49 presented with lethargy, pulse rates in the 130s, and systolic blood pressure in the 80s despite fluid administration. R49 had urinary retention upon arrival; the catheter was changed with a return of nearly 900 milliliters of purulent urine. R49 has a history of multidrug-resistant bacterial infections. A physician progress note dated 11/21/2025 documents urine culture results of greater than 100,000 colony-forming units (CFU)/mL of mixed bacteria, continued IV antibiotics, and placement of bilateral urinary stents on 11/17/2025. On 12/08/2025 at 1:47 PM, V5 and V6, CNAs, were	S9999		

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S9999	Continued from page 8 questioned regarding EBP. V6 stated PPE is worn whenever entering the room. V5 stated that for catheter care, gown and gloves are worn and that staff identify residents on precautions by posted signage and PPE supplies. V5 correctly described catheter cleaning as a downward motion approximately four inches from the insertion site. V5 and V6 confirmed that gowns were not worn during R49's transfer and catheter care. At 1:59 PM, V7 confirmed she did not clean the four inches of catheter tubing and did not wear a gown during catheter care. On 12/09/2025 at 10:33 AM, V9, Infection Preventionist (IP), stated that catheter changes are completed per physician orders and documented in nursing notes or on the MAR or Treatment Record. On 12/10/2025 at 9:35 AM, V9 stated that the purpose of EBP is to protect residents from staff-transmitted germs and that staff are expected to wear gown and gloves when EBP is in place, particularly for residents with urinary catheters. On 12/09/2025 at 10:36 AM, V10, Licensed Practical Nurse/Wound Nurse, stated that per the 10/03/2025 urology note, R49's catheter was to be changed monthly. V31, MDS Coordinator, stated that she rounded with V33, R49's primary physician, who changed the catheter order to "as needed" without consulting the urology office. V10 stated that urine output monitoring would be documented on CNA task sheets. At 12:22 PM, V10 stated R49 was seen by urology in April, May, October, and November 2025. V10 further stated that R49's catheter was last changed on 06/23/2025 and that there was no documentation of catheter changes until 11/16/2025, no follow-up with urology regarding the order change, and no documentation of urine output monitoring until 12/04/2025, when an audit was completed by V2, Director of Nursing. On 12/09/2025 at 12:02 PM, V34, Urology Nurse for V35, stated that R49 was seen as a new patient in April 2025 and again in October 2025, and that V35 saw R49 during hospitalizations in May and November 2025. Provider notes indicated that R49's catheter was to be changed monthly, and no catheter changes were completed in the clinic. V34 stated that the facility should monitor for UTI signs such as changes in urine color or characteristics, cloudiness or blood, and complaints of flank pain. Standard nursing practice also includes measuring, recording, and monitoring urinary catheter output. Decreased output may indicate UTI. Failure to change a catheter can contribute to UTIs, and delayed identification or treatment of UTI can lead to sepsis. V34 stated that if these interventions had been	S9999		

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S9999	Continued from page 9 performed, R49's hospitalization may have been prevented. On 12/10/2025 at 11:04 AM, V36, LPN, stated that she sent R49 to the hospital in November after the night nurse, V37, LPN, reported that during the 5:00 AM medication pass R49 was mumbling and experiencing swallowing difficulties. V36 stated she assessed R49's vital signs due to concern for possible sepsis given R49's history. R49 had minimal urine output, low pulse and blood pressure, and labored breathing. On 12/10/2025 at 11:41 AM, V37 stated that R49 appeared stable until approximately 5:30 AM, when a CNA reported that R49 was shaking and did not look well. Vital signs were checked and reported as normal, and the information was passed on in report. V37 stated she could not recall R49's urinary output that night, as nurses do not routinely document urine output. 2.) On 12/09/2025 at 1:25 PM, V38 and V39, CNAs, transferred R2 from the toilet to her wheelchair in the 200-unit shower room. V38 pushed R2's wheelchair across the hall into R2's room, and R2's urinary catheter tubing was observed dragging on the floor, as confirmed by V39. A clip was attached to the tubing but was not used to keep the tubing off the floor. V39 removed R2's urinary collection bag from beneath the wheelchair and held it above the level of R2's bladder, causing urine to drain back toward the bladder, then placed the bag on R2's lap. Cloudy sediment was observed in R2's urine. V38 and V39 transferred R2 into bed using a full mechanical lift. The CNAs did not wear gowns during the transfers or while handling R2's urinary catheter, despite signage outside R2's room indicating Enhanced Barrier Precautions and the requirement to wear gowns for high-contact care. V39 acknowledged that the clip could be used to keep tubing off the floor and confirmed that the urinary collection bag had been raised above the bladder. R2's care plan dated 09/24/2025 documents use of a urinary catheter. A urine culture and sensitivity dated 12/08/2025 documents 50,000–99,999 CFU/mL of Escherichia coli (ESBL) and 25,000–50,000 CFU/mL of vancomycin-resistant Enterococcus faecalis. 3.) On 12/08/2025 at 9:54 AM, V40, R5's family member, stated concerns that R5 experiences frequent UTIs and that nursing staff do not always follow up in a timely manner when urinalysis is requested. V40 stated that nurses must request orders from the physician and that	S9999		

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S9999	Continued from page 10 results sometimes take weeks. R5's MDS dated 11/10/2025 documents severe cognitive impairment, total bowel and bladder incontinence, and dependence on staff for toileting hygiene. A nursing note dated 09/17/2025 documents that V40 reported R5 complained of burning with urination and foul-smelling urine. The physician was notified; however, there is no documentation that a urine sample was collected until 09/19/2025, nor are results documented from that sample. Nursing notes document that another urine sample was collected on 09/24/2025, with results received on 09/26/2025 (nine days after symptom onset). Orders were received for Keflex 500 mg twice daily for 10 days. R5's urine culture and sensitivity dated 09/26/2025 documents 50,000–99,999 CFU/mL of E. coli. On 12/09/2025 at 12:14 PM, V31, MDS Coordinator, stated that laboratory pickup occurs Monday through Friday and that on weekends staff must transport specimens to the local hospital. V9, Infection Preventionist, and V31 were asked to provide documentation that R5's 09/19/2025 urine sample was sent to the laboratory. On 12/09/2025 at 3:06 PM, V2, Director of Nursing, stated that no additional documentation was available regarding R5's urine samples or results. (A)	S9999		