STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000869	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven of Paris	**1011 NORTH MAIN STREET , PARIS, Illinois, 61944**

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S0000	Initial Comments Facility Reported Incident of 11/16/25-IL2673615 Complaint investigation 25611169/2671157	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 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 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	S9999		

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

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S9999	Continued from page 1 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. 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. These requirements were not met as evidenced by: Based on interview and record review the facility failed to ensure sufficient lighting in a resident's bedroom and failed to provide adequate supervision for a restless resident with dementia. These failures resulted in a fall for one (R6) of three residents reviewed for accidents, causing a brain bleed and skin tears to the right shoulder, right hand, and right forearm on the total sample list of 17. Findings include: The facility's Falls and Fall Risk Management Policy, dated March 2018, documents that based on previous evaluations and current data, staff will identify interventions related to a resident's specific risks and causes to prevent falls and to minimize complications from falls. The policy defines a fall as unintentionally coming to rest on the ground, floor, or other lower level, not as a result of an overwhelming external force.	S9999		

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S9999	Continued from page 2 Fall risk factors identified in the policy include:Environmental factors: wet floors, poor lighting, incorrect bed height or width, obstacles in the footpath, improperly fitted or maintained wheelchairs, and unsafe or absent footwear;Resident conditions: fever, infection, delirium and other cognitive impairments, pain, lower extremity weakness, poor grip strength, medication side effects, orthostatic hypotension, functional impairments, visual deficits, and incontinence; andMedical factors: arthritis, heart failure, anemia, neurological disorders, and balance and gait disorders.The policy documents that staff are to use resident-centered approaches to managing falls and fall risk. These approaches include:Staff, with input from the attending physician, will implement a resident-centered fall prevention plan to reduce specific fall risk factors for each resident at risk or with a history of falls;A systematic evaluation of a resident's fall risk may identify several possible interventions, and staff may prioritize interventions (e.g., trying one or a few interventions at a time rather than many at once);Examples of initial approaches include exercise and balance training, rearranging room furniture, improving footwear, and adjusting lighting; andIn conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding for osteoporosis, as applicable) to minimize serious consequences of falling.The policy further documents that staff should monitor subsequent falls and fall risk by documenting each resident's response to interventions intended to reduce falls or fall risk. If interventions are successful in preventing falls, staff are to continue those interventions. R6's Minimum Data Set (MDS) dated 9/24/25 documents diagnoses of non-Alzheimer's dementia with behavioral disturbances and severe cognitive impairment. The MDS also documents that R6 had post-traumatic stress disorder (PTSD). R6's Care Plan, initiated on 7/27/25, documents a history of falls related to decreased safety awareness and includes an intervention dated 7/29/25 for staff to walk with R6 when he exhibited signs of restlessness. R6's Care Plan, initiated on 6/11/25, documents a history of falls related to medications (psychotropic, diuretic, cardiovascular, and pain medications) and unspecified medical factors. This Care Plan included an intervention to provide adequate lighting.	S9999		

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S9999	Continued from page 3 R6's Fall Risk Evaluation dated 9/7/25 documents that R6 was at high risk for falls. R6's Electronic Medical Record (EMR) contains a nursing note dated 11/13/25 documenting that R6 was periodically attempting to stand and walk independently throughout the night. The note documents that staff successfully implemented the Care Plan intervention by walking alongside R6 using a walker and gait belt until R6 became tired and requested to go to bed. R6's Incident Investigation Report documents that R6 was found on the floor in his bedroom on 11/16/25 at 4:17 AM. The report documents that R6 sustained a fall with physical harm, including a hematoma to the right side of his head above the eye, two skin tears to the right shoulder, a skin tear to the right hand, and a skin tear to the left forearm. On 12/16/25 at 12:33 PM, V20, Certified Nursing Assistant (CNA), stated that R6 had been up all night on 11/16/25 at the nurses' station due to agitation, restlessness, and attempts to hit staff and other residents. V20 stated R6 appeared "busy" that night and, in her professional opinion, R6 should not have been put to bed at that time because he repeatedly stood up and sat down. V20 stated she was an agency CNA and that suggesting R6 remain up would not have been well received by facility staff. V20 further stated that at approximately 4:30 AM, while sitting at the nurses' station, she heard a thud and went to R6's room, where she found the lights off and R6 lying on the floor at the end of his bed with blood coming from his head. V20 stated the television was hanging off the wall, with cords wrapped around R6's leg. On 12/16/25 at 2:36 PM, V19, CNA, stated that R6 was restless and repeatedly attempting to get up and down from his wheelchair the night of the fall. V19 stated she put R6 to bed and that the bedroom lights were off. V19 stated that V20 called for help at approximately 4:00 AM, reporting that R6 had fallen. V19 stated she entered the room and found R6 lying on his back on the floor with blood on his head and on the floor, and that R6's left foot was tangled in the television cords. On 12/16/25 at 10:04 AM, V14, Licensed Practical Nurse (LPN), stated she was the nurse caring for R6 on the night of the unwitnessed fall on 11/16/25. V14 stated that R6 was at high risk for falls, had fallen several times the prior week, and had been moved to the secured dementia unit for closer monitoring. V14 stated R6 was sitting with staff at the nurses' station around 2:30 AM due to restlessness, fidgeting, and attempts to get	S9999		

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S9999	Continued from page 4 out of his wheelchair. V14 stated that V19 and V20, CNAs, toileted R6 and put him to bed. V14 stated that at approximately 4:30 AM, V19 notified her that R6 had been found on the floor in his room and was bleeding from his head and arms. On 12/17/25 at 9:29 AM, V2, Regional Nurse Consultant (RNC), stated that if it had been her decision, she would not have discontinued the ten-minute safety checks when R6 was transferred to the dementia unit one week prior. V2 further stated that staff on the dementia unit may lack the necessary knowledge to properly care for residents with dementia. On 12/17/25 at 12:36 PM, V26, Champaign County Coroner, confirmed that R6's cause of death was determined to be complications from an unwitnessed fall, resulting in bleeding in the space around the brain (subdural hematoma). (A)	S9999		