STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145422	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Havens Senior Living	1790 South Fairview Avenue Decatur, IL 62521

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172 Based on observation, interview, and record review the facility failed to protect the resident's right to a dignified existence by failing to knock and gain permission before entering a resident's room and by failing to provide timely care. These failures affected five of five residents (R36, R4, R19, R40 and R78) reviewed for Dignity on the sample list of 39. Findings Include: The facility's Resident Rights Protocol for All Nursing Procedures policy dated August 2008 documents residents have the right to dignity and respect. When staff needs to enter a resident's room, the staff must first knock and gain permission before entering the resident's room. The staff must also introduce themselves if the resident is unfamiliar with them and explain the reason for their visit. 1. R36's Medical Diagnoses list dated August 2024 documents R36 has Cataracts and Anxiety. R36's Minimum Data Set, dated dated dated [DATE] documents R36 is cognitively intact. On 8/11/24 at 10:30 AM V8 Licensed Practical Nurse stated R36 recently had cataract surgery on one eye and is scheduled to have the other eye done in a week or so. V8 stated R36 still has some trouble with his vision. On 8/11/24 at 11:05 AM R36 stated he is tired of staff coming in his room without knocking. R36 stated he cannot see very well and they often come in and are standing right next to his bed before they say anything and he gets startled when they start talking. R36 stated this causes him to feel anxious and uneasy and he already struggles with Anxiety. R36 stated most of the older staff knock but everyone else just comes in no matter if he is in bed, using the urinal, or using the bathroom. On 8/11/24 at 11:25 AM V8 LPN walked into R36's room without knocking or asking permission. On 8/12/24 at 3:25 PM V1 Administrator stated staff should knock on resident's room doors prior to entry, introduce themselves, and ask permission to enter. 20892 (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 8/13/24 at 11:00 AM, a group of four residents (R4, R19, R40, and R78) met for the Resident Council group meeting task for the facility's annual certification survey. R78 is the facility's President of the Resident Council. During the group meeting, when asked about the timely answering of the call lights, all four residents (R4, R19, R40, R78) stated it takes staff a very long time to answer call lights. Sometimes it takes over an hour. All four residents stated they have waited so long for call lights to be answered that they ended up soiling themselves. This makes them feel frustrated and embarrassed. On 8/13/24 at 11:10 AM R4 stated sometimes her call light will be on and a staff member will come in and shut the light off and tell her they will tell her assigned Certified Nurses Assistant (CNA). R4 stated the issues is, your assigned CNA never comes and you have to turn the light back on and continue to wait. On 8/13/24 at 11:12 AM R78 President of Resident Council stated many residents have brought this issue to the attention of facility staff during the monthly resident council meetings, however it only gets better for about a week and then staff go back to not timely answering the call lights. Resident Council Meeting Minutes and Grievance logs were reviewed from January 2024 to July 2024. Both the minutes and log document many concerns from residents regarding the timely answering of call lights. On 8/14/24 at 2:00 PM V1 Administrator stated she has trained and educated staff over and over about answering call lights in a timely fashion however it is obvious they are not following her direction. V1 confirmed call lights need to be answered timely in order to provide quality care and meet the needs of the residents.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 49492 Based on observations, interview, and record review the facility failed to ensure a resident was deemed appropriate to self-administer medications before leaving medications unattended for residents to self-administer. This failure affected two of two residents (R72, R90) reviewed for self-administration of medications in the sample list of 39. Findings Include: The Medication Administration Policy dated March 2014 documents the same licensed nurse or QMA (Qualified Medication Aides) who prepare the medications shall also administer those medications to residents for whom they are ordered. The same policy documents residents will be positively identified (i.e. arm band, facial recognition, face sheet photograph, Medication Administration Record photograph, confirmation of identity from another direct care provider) prior to medication administration and shall not be left alone until the medication is consumed or refused. 1. On 8/11/24 at 8:35 AM V10 Registered Nurse entered R72's room with a medication cup containing several unidentified medications. V10 then set the medication cup on R72's bedside table with a small cup of water and left the room before R72 consumed the medications. R72's Physician Orders Set dated August 2024 does not contain a physician order for self-administration of medications. R72's Care Plan dated 9/20/23 documents staff are to give R72's medications as ordered and monitor/document for side effects and effectiveness. On 8/14/24 at 10:42 AM V4 Infection Control Nurse/Wound Nurse stated nurses are not supposed to leave medications at the bedside. The nurse is supposed to watch the residents consume the medications before leaving. 50430 2. On 8/11/24 at 8:27 AM a medication cup was sitting on R90's bedside table with three unknown pills. There were two white circular pills and one yellow oval pill. R90 is in a private room and was not in his room. R90's Physician Orders Set dated August 2024 does not contain a physician order for self-administration of medications

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 49492 Based on interview and record review the facility failed to notify the physician and dietician of a change in condition (significant weight change) for one of one resident (R10) reviewed for weights on the sample list of 39. Findings Include: The facility's undated Weight Assessment and Intervention Policy documents any weight change of greater than five pounds within 30 days will be retaken for confirmation. If the weight is verified, nursing will immediately notify the dietitian in writing. Verbal notification must be confirmed in writing. The facility's undated Notification Of Resident Change In Condition Policy documents a licensed nurse shall promptly inform the resident, consult the resident's physician, notify the resident's legal representative or an interested family member of a significant change in the resident's physical, mental or psychosocial status. For example a deterioration in health, mental or psychosocial status. The same policy documents a clinical change in condition is determined by resident visualization, medical record review, clinical assessment findings and care plan review. Review of high-risk clinical issues such as skin breakdown, falls, weight loss, dehydration and others are conducted on a daily basis. R10's Physician Order Sheet (POS) dated August 2024 documents an order that started on 7/12/24 for daily weights before breakfast, every day shift and notify physician of weight gain of more than three pounds (lbs) in one day and more than five pounds (lbs) in one week. R10's Weight Log documents weight fluctuations for the following dates: ~ 7/18/2024 217.1 lbs to 7/19/2024 211.0 lbs = 6.1 lbs weight loss ~ 8/01/2024 216.8 lbs to 8/02/2024 231.4 lbs = 14.6 lbs weight gain ~ 8/05/2024 231.0 lbs to 8/06/2024 235.6 lbs = 4.6 lbs weight gain ~ 8/06/2024 235.6 lbs to 8/07/2024 225.0 lbs = 10.6 lbs weight loss ~ 8/08/2024 226.6 lbs to 8/09/2024 231.8 lbs = 5.2 lbs weight gain ~ 8/09/2024 231.8 lbs to 8/10/2024 224.1 lbs = 7.7 lbs weight loss R10's electronic medical record does not include documentation of physician or dietician notification of R10's significant weight fluctuations. On 8/12/24 at 11:22 AM V4 Wound Nurse confirmed nursing should verify significant weight changes are accurate and if so, notify the resident's physician and the facility's dietician.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 49492 Based on interview and record review the facility failed to protect the residents' right to be free from verbal abuse by another resident. This failure affects two of three residents (R72, R253) reviewed for abuse in sample list of 39. Findings Include: The facility's Abuse Prevention Program dated October 2022 documents the facility affirms the right of it's residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. One way this will be done is by identifying occurrences and patterns of potential mistreatment. Verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individuals' age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm or saying things to frighten a resident. R72's Care Plan dated 6/5/2024 documents R72 is alert and oriented. The same Care Plan documents R72 has a behavior problem related to refusing care, cursing and hollering at staff, noncompliance, and making inappropriate comments about other residents in a joking manner. R253's Care Plan dated 8/01/2024 documents R253 is alert and oriented. The same Care Plan documents R253 uses anti-anxiety medications related to anxiety disorder. On 8/12/24 at 9:07 AM R72 stated he had just returned from the hospital and had a new roommate (R253) that had a cough and would holler/yell for the nurse on a regular basis. R72 stated it got on his nerves and he lashed out at R253 and the staff by yelling and cursing at them. On 8/13/24 at 10:39 AM R253 stated that R72 yelled and cursed at him when R72 returned from the hospital on night of 7/31/24. R253 stated that R72 was very loud and upset. R253 stated that R72 made him upset by yelling and cursing at him. The Facility Reported Incident dated 7/31/24 documents a verbal altercation occurred between R72 and R253 on 7/31/24 at 10:22 PM. Both R72 and R253 are cognitively intact. After conducting an investigation and interviewing staff and residents it was found that R72 was upset because his new roommate was coughing and hollering out. R72 then began yelling and cursing at R253 and staff. On 8/14/24 at 10:42 AM V4 Wound Nurse stated there was an incident of verbal abuse between R72 and R253. V4 stated that R72 returned from the hospital and had a new roommate (R253) which made R72 unhappy. V4 stated R72 began yelling and swearing at R253. V4 stated that staff separated the residents and moved R253 to another room. V4 confirmed this incident would be considered verbal abuse.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 49492 Based on interview and record review the facility failed to submit information for Preadmission Screening and Resident Review (PASARR) for a Level I evaluation for one of two residents (R2) reviewed for PASARR on a sample list of 39. Findings Include: The facility's undated Admission Policy documents all potential admissions will have participated in the Pre-Screening process or will have wavered rights for Medicaid funds for one year, or be approved as an emergency admit by the PASARR agency. The Facility Census Report dated 8/14/24 documents R2's admitted was 3/26/21. R2's Medical Diagnoses List dated August 2024 documents R2 is diagnosed with Delusional Disorder. On 8/12/24 at 11:46 AM V6 Social Service Director stated that no Level I or Level II PASARR had been completed for R2.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50430 Based on observation, interview, and record review the facility failed to complete dressing changes as ordered by the physician for one of four residents (R90) reviewed for wounds in the sample list of 39. Findings Include: The facility's Pressure/Skin Breakdown-Clinical Protocol policy dated January 2017 documents, The Physician will authorize pertinent orders related to wound treatments, including pressure redistributing surfaces, wound cleansing and debridement, dressings and topical agents. The facility nursing staff will carry out treatments as ordered by Physician. R90's Physician Order dated 7/16/24 documents Cleanse R (right) medial foot and R heel with wound cleanser/NS (Normal Saline), pat dry, apply gauze moistened betadine to wound beds, cover with (padded dressing), wrap with (gauze wrap), and secure with retention tape. Every shift (twice daily) for wound care. On 8/11/24 at 9:45 AM R90's right foot wound dressing was dated 8/9/24. The dressing was visibly soiled with a dark brown substance. On 8/11/24 at 10:15 AM V4 Wound Nurse stated R90 is supposed to have a dressing change to the right medial foot twice daily. On 8/11/24 at 11:15 AM V17 Licensed Practical Nurse stated R90 has a twice daily dressing change to the right foot. V17 stated she ran out of time last night and passed on to the night shift nurse that she would need to complete dressing change. V17 stated, I guess she didn't do it either. On 8/13/24 at 1:10 PM V14 Physician's Assistant for Vascular Surgery stated if the dressing on R90's right foot wound is not being changed as ordered it would be a concern for R90 because the wound can worsen quickly. On 8/13/24 at 1:38 PM V4 Wound Nurse stated if the dressing is not being changed as ordered by the physician the wound can worsen.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 32172 Based on observation, interview and record review the facility failed to properly clean and maintain a Continuous Positive Airway Pressure (CPAP) mask and failed to maintain and store respiratory equipment in a clean sanitary manner, off the floor and failed to date respiratory equipment when changed. These failures affect four of six residents (R14, R34, R37, R41) reviewed for respiratory/oxygen on the sample list of 39. Findings Include: The facility's Departmental (Respiratory Therapy) Prevention of Infection Policy with a revision date of August 2008 documents the following: Change pre-filled humidifier when the water level becomes low. Change the oxygen cannula and tubing every seven (7) days, or as needed. Keep the oxygen cannula and tubing in a plastic bag when not in use. 1. R14's Physician Order Sheet (POS) dated August 2024 documents an order for a Continuous Positive Airway Pressure (CPAP) mask applied at 19 millimeters of water (mmH2O) at bedtime and remove in the morning. There is no order to clean the CPAP mask. On 8/11/24 at 10:42 AM R14's Continuous Positive Airway Pressure (CPAP) mask was on the bedside table. R14's mask appeared very soiled with white and red dots all over the inside of the mask. R41's CPAP mask was not stored in a sanitary way. On 8/11/24 at 10:45 AM V8 Licensed Practical Nurse (LPN) confirmed the mask appeared very dirty and stated she believes nursing staff clean CPAP masks on Sunday nights but that she will clean the mask now since it appears it hasn't been cleaned in a while. On 8/12/24 at 3:27 PM V1 Administrator stated CPAP masks should be cleaned per policy or as needed. If a mask appears dirty it should definitely be cleaned. 38780 2. R34's Face Sheet dated 8/13/24 documents R34 is diagnosed with Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure with Hypoxia, and Congestive Heart Failure. R34's Physician Order Sheet (POS) dated August 2024 documents an order for oxygen at two liters every shift and as needed to keep oxygen saturation above 92 percent. The same POS documents an order for oxygen tubing and humidifier bottle to be changed every seven days while on oxygen, on the night shift, every Sunday and to date the tubing when changed. On 8/11/24 at 11:53 AM R34 was wearing oxygen by nasal cannula and the tubing was not dated. 3. R37's Face Sheet dated 8/13/24 documents R37 is diagnosed with Chronic Obstructive Pulmonary Disease, Shortness of Breath, and Chronic Respiratory Failure with Hypoxia. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R37's Physician Order Sheet (POS) dated August 2024 documents and order for oxygen at three liters via nasal cannula continuous for Shortness of Breath. The same POS documents an order for oxygen tubing and humidifier bottle to be changed every seven days while on oxygen, on the night shift, every Sunday and to date the tubing when changed. On 8/11/24 at 10:22 AM R37's oxygen tubing was laying on R37's bed. R37's oxygen tubing was not dated. R37's humidifier bottle was dated 6/9/24. On 8/12/24 at 10:56 AM R37's oxygen tubing was laying on R37's bed and the oxygen tubing was not dated. There was no humidifier bottle present in oxygen concentrator. 4. R41's Face Sheet dated 8/13/24 documents R41 is diagnosed with Chronic Obstructive Pulmonary Disease, Heart Failure, Congestive Heart Failure, and Respiratory Failure with Hypercapnia. R41's Physician Order Sheet (POS) dated August 2024 documents an order for oxygen at two to four liters via nasal cannula as needed. The same POS documents an order for oxygen tubing and humidifier bottles to be changed every seven days while on oxygen, on the night shift, every Sunday and to date the tubing when changed. On 8/11/24 at 10:46 AM R41 was laying in bed wearing two liters of oxygen via nasal cannula. R41's oxygen tubing was not dated. R41's humidifier bottle was dated 7/23/24 and was empty. On 8/11/24 at 10:55 AM V8 Licensed Practical Nurse stated humidifier bottles and oxygen tubing are to be changed by staff on Sunday nights. On 8/12/24 at 3:25 PM V1 confirmed staff should be changing and dating oxygen tubing every Sunday night and tubing should be stored in a bag.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38780 Based on observation, interview, and record review, the facility failed to maintain sanitary food storage areas and failed to maintain sanitary food service areas (floors, walls, equipment surfaces). These failures have the potential to affect all 98 residents in the facility. Findings Include: 1. On 8/11/24 at 8:31 AM the kitchen walk-in cooler floor had food debris and packets of unopened butter on the floor. 2. On 8/11/24 at 8:40 AM a fan facing the drain board area was soiled with accumulations of gray colored dust. 3. On 8/11/24 at 8:40 AM the floor areas throughout the kitchen and adjacent dishwashing areas were heavily soiled with accumulations of decomposing food and grease deposits. Thick deposits of dark grease and decomposed food covered all areas of the baseboards and adjacent floor and wall areas of the dishwashing area and kitchen. The drain board area where staff remove clean dishes from the dishwasher was heavily soiled with food particles, dirt and grease deposits. 4. On 8/12/24 at 9:12 AM the food prep table had an open package of butter, miscellaneous empty packages, and food debris on top. 5. On 8/12/24 at 9:12 AM the garbage cans in the kitchen area were full and uncovered. On 8/12/24 at 9:12 AM the floor areas remained as above. V7 Dietary Manager was present and stated dietary staff have a daily cleaning schedule and the kitchen needs a deep clean. V7 confirmed the food prepared in the kitchen is available for all residents to consume. The Long-Term Care Facility Application for Medicare and Medicaid report dated 8/12/24 documents 98 residents reside in the facility.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 50430 Based on observation, interview and record review the facility failed to ensure resident living spaces and resident rooms were organized, clean, and free of debris, with walls and furniture in good repair. These failures have the potential to affect all 98 residents residing in the facility. Findings Include: The facility's undated Infection Prevention and Control Manual/ Environmental Services/ Housekeeping/ Laundry policy documents the facility shall be maintained in a clean and sanitary condition with a written schedule of cleaning and decontamination based on the area in the facility, type of surface to be cleaned, type of soil present and tasks being performed in the area. On 8/11/24 and 8/12/24 at 9:15 AM the dining room floors were sticky. The main hallway from the entry way to the conference room was sticky and dirty with multiple small debris items present and food debris and napkins were on the dining room floor. On 8/11/24 during the facility tour, between 10:30 AM and 11:00 AM three bedside tables with peeling, cracking sharp edges were observed in resident rooms. One bedside dresser with broken drawers and a drawer face hanging off was observed in a resident room. Boxes and other resident care items were piled in corners and on the floor in resident rooms. Multiple resident bathrooms and rooms had debris on the floor and under the bed. Resident room bathrooms had sticky floors, wire containers hanging off the walls with one screw, and trash cans without liners that had dirt and grime stuck to the bottom of the cans. Peeling and torn drywall and paint, small holes and scrapes were observed on the walls throughout the facility. The facility court yard area which is visible to residents, had broken chairs on the ground and the grass was un-mowed with weeds approximately 12- 18 inches high. On 8/13/24 at 11:30 AM V1 Administrator confirmed she has had complaints from residents and families regarding housekeeping and other staff not doing a thorough job cleaning the facility. V1 stated she has talked with her staff, but it is still not getting done right. V1 acknowledged the facility appears dirty and is in need of repairs. On 8/14/24 at 1:30 PM V9 Maintenance/Housekeeping Director stated housekeepers are trained on what to do when they are hired. V9 stated each housekeeper has an assigned area that they clean and it is usually the same area each time. V9 stated currently the facility only has three housekeepers and V9 is trying to hire three more. V9 stated he has not been doing cleaning audits because he has been busy fixing things in the facility. On 8/12/24 at 10:26 AM V16 (R91's family member) stated R91's room isn't very clean, and staff do not sweep the floors in the rooms. V16 stated there is always food and dirt on the floor and under R91's bed. V16 stated stuff is piled all over the room and along the walls, wipes are stacked on the bedside table and boxes are on the floor. V16 stated he has made the facility aware and they say they will get to it but it looks the same every time he visits. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Quality Assurance Grievance Log dated 7/25/24 documents residents have concerns with rooms not being dusted, clothing being put on the wrong side of the room, and beds not being made. The facility's February Quality Assurance Grievance Log dated 2/29/24 documents housekeeping is not sweeping, mopping and cleaning bathrooms and staff are not making beds. The Long-Term Care Facility Application for Medicare and Medicaid report dated 8/12/24 documents 98 residents reside in the facility.

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Fair Havens Senior Living	1790 South Fairview Avenue Decatur, IL 62521

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 38780 Based on observation, interview, and record review the facility failed to maintain an effective pest control program by failing to prevent drain flies and flies in the kitchen area. This failure has the potential to affect all 98 residents in the facility. Findings Include: On 8/11/24 at 8:40 AM the floor areas throughout the kitchen and adjacent dishwashing areas were heavily soiled with accumulations of decomposing food and grease deposits. Thick deposits of dark grease and decomposed food covered all areas of the baseboards and adjacent floor and wall areas of the dishwashing area and kitchen. The drain board area where staff remove clean dishes from the dishwasher was heavily soiled with food particles, dirt and grease deposits. Live drain flies and flies were observed in the area of the mechanical dishwasher. On 8/12/24 at 9:12 AM the floors remained as previously stated with live drain flies and flies present. On 8/12/24 at 9:12 AM the garbage cans in the kitchen area were full and uncovered. Live flies were observed in the food prep area. V7 Dietary Manager stated maintenance handles the pest control for the kitchen. On 8/12/24 at 9:45 AM V9 Maintenance Director stated the pest control company comes out monthly. V9 stated he was not aware of any current fly issues in the kitchen. The Long-Term Care Facility Application for Medicare and Medicaid report dated 8/12/24 documents 98 residents reside in the facility.