

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145422	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Fair Havens Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34058</p> <p>Based on observation, interview, and record review, the facility failed to maintain the shower rooms in a homelike and functional condition. This failure has the potential to affect all 102 residents residing in the facility.</p> <p>Findings include:</p> <p>On 12/4/24 at 4:20 PM, the facility's shower room on the 200 hall was in state of disarray. There was a plastic 5 gallon bucket approximately four inches full of hardened cured cement tile mastic with a steel mixing blade stuck inside. There was a pile of one inch square tiles from the demolition of the shower floor. The shower floor had 15 twelve inch square tiles installed with another 15 needing to be installed including the cut tiles to form a border. There was a four foot long 30 inch wide construction roller cart with boxes of the 12 inch tiles. There was an electric cutting tool laying on the floor. There was a two pound [NAME] hammer on the floor.</p> <p>On 12/4/24 at 4:20 PM, V12, Maintenance Director stated the facility had a guy working on the shower room but had not shown back up to finish the job. V12 further stated the replacement of the tile floor had not been 6 months in duration. V12 stated the shower rooms on the 300 hall was also not in functional condition but the shower rooms on the 100 and 400 halls were in working order.</p> <p>On 12/4/24 at 4:30 PM, the shower room on the facility's 300 hall was in obvious use as a storage room. There was 2 cushioned recliners, a full body mechanical lift, a sit to stand mechanical lift, two housekeeping carts, two mop buckets, two wheelchairs, and two walkers. One shower area had the valve handles removed to make it non-functional. The second shower stall had approximately 50 missing one inch square floor tiles in total from several areas.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 12/5/24 at 10:54 AM, V1 Administrator, repeated that there are 2 working shower rooms in the facility, one on the 100 hall and one on the 400 hall. V1 stated the 200 and 300 hall shower rooms had to be shut down for safety. V1 informed that the floor tiles had been coming up for years but it had always been just one or two tiles that could be set back in place, but the occurrence had been happening more and more and water was getting underneath the tiles. V1 explained the shower rooms on 200 and 300 halls had been shut down approximately two months. V1 further stated she had a company come out to look at the shower rooms to give an estimate, but then stated she could not provide the estimate because the company never sent one. V1 also stated the facility Human Resources employee (V16) had a brother (V17) who did this type of work but lived out of town and was not available but did have a local friend (V18) who did handyman type of work and also came to look at the shower room, but V18 was not licensed or bonded so the facility could not use him. V1 then stated she thought it was V12, Maintenance Director, and V13, Maintenance Assistant, who had started to work on the shower floor but had too much other work in the facility to keep on doing the work in the shower room.</p> <p>On 12/5/24 at 1:15 PM, R15 stated he had been going to other halls when he gets his shower. R15 stated he had heard the other shower rooms had mold in them. R15 stated the floors in the showers he had been using were black. R16 (R15's roommate) stated he had lived at the facility for about a year and a half and the shower room on 300 hall had been non-functional for about a year. R16 stated there had been a lot of discussion about the shower rooms in the resident council meeting about 7 or 8 months prior. The managers keep telling us that they have gotten estimates but they are too expensive. R16 confirmed he thought the showers had mold in them but he was not a mold expert.</p> <p>On 12/7/24 at 11:15 AM, in addition to the aforementioned disarray in the 200 and 300 shower rooms, the shower room on the 100 hall had a shower stall which had blackened areas in the rear corner covering both adjacent walls and the floor in a 3 foot triangle shape. These blackened areas were in a spotted arrangement with radiating strands and resembled mold. There were approximately one dozen flying insects approximately three sixteenths of an inch long with opaque wings, commonly referred to as sewer flies or fruit flies around the shower drain and along the walls.</p> <p>The shower room on the 200 hall was unchanged from the previous description with demolition and construction debris, tools, and carts.</p> <p>The shower room on the 300 hall was noted to have a bathing tub which was full of items such as 2 metal folding chairs, a plastic laundry basket, several plastic hangers, food wrappers, and a plastic 3 drawer bureau kit. There was also yellow plastic caution ribbon tied around one of the shower valve handles and the handle was leaking water. The floor of this shower stall had blackened areas along the floor wall junction in an area approximately 6 feet by 2 feet on the floor and up the wall.</p> <p>The entry door to the 400 hall shower room did not close completely, having a bolt plate protruding from the door which was coming in contact with the door frame. One of the shower stalls did not have a handle on the valve which rendered this stall non-functional. The second shower stall had a valve handle which would not turn on the water with a simple turn, the handle needed to be pulled outwards approximately one and one half inches, then turned to get the water to come out. The chrome face plate around the valve handle had loosened screws to allow the movement of the handle required to make the water turn on. The floor of this shower stall had blackened areas in the rear corner along the floor and wall in an area approximately 4 feet by 1 foot.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 12/7/24 at 1:40 PM, R19 stated she had noticed the hammer and the piles of tile in the shower room and would not have that at her house.</p> <p>On 12/7/24 at 1:50 PM, R20 stated in the shower room where he usually goes (on the 200 hall) he would not have his house look like that but did not want to complain about it.</p> <p>On 12/7/24 at 2:00 PM, R22 stated she noticed a hammer in the shower room on the 200 hall and only has a small area of tile that is finished. R22 stated she would not have her house looking like that before she was admitted to this facility.</p> <p>On 12/7/24 at 2:10 PM, R23, communicating with simple utterances of mmm-hmm (yes), uh-uh (no), hand gestures, and head nods, emphatically expressed she had been in the shower room under construction and had seen the hammer and broken up tiles, didn't like it (was vigorously shaking her fist), and would not have had her house in this condition.</p> <p>On 12/7/24 at 2:20 PM, R24 stated they were still working on the shower room and she had been asking frequently when this project was going to be completed. R24 expressed she was tired of having to be dragged to another hall to be able to have a shower. R24 stated there were buckets and hammers and who knows what all in there. R24 stated the construction going on in the shower room had been about a year in duration and maybe the facility needed more than 2 maintenance men.</p> <p>The facility Resident Roster and Form 802 Resident Matrix, both dated 12/3/24, document 102 resident reside in the facility.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34058</p> <p>Based on observation, interview, and record review, the facility failed to accurately assess residents for their smoking status, and failed to accurately encode minimum data sets for tobacco use. This failure affects three residents (R11, R12, R13) out of five reviewed for smoking status on the sample list of 24 residents.</p> <p>Findings include:</p> <p>The facility's (undated) smoking schedule documented R9, R10, R11, R12, and R13 as current smokers. This schedule documents the activity department and laundry department are the staff responsible for supervising resident smokers.</p> <p>On 12/4/24 at 2:20 PM, V10, Activity Director, confirmed the current resident smokers.</p> <p>On 12/4/24 at 2:30 PM, V11, Laundry Aide, confirmed the list of resident smokers.</p> <p>1. R11's Minimum Data Set, dated dated dated [DATE], Section J1300 documents R11 as no current tobacco use. R11's Care Plan dated with the most recent revisions on 12/5/24 and which is informed by the minimum data set, does not document any focus area for smoking. R11's Smoking assessment dated [DATE] documents R11 does not light her own cigarettes safely and requires assistance to light her cigarettes.</p> <p>2. R12's Minimum Data Set, dated dated dated [DATE] Section J1300 documents no for current tobacco use. R12's Smoking assessment dated [DATE] is incomplete but does document R12 does not light his own cigarette safely.</p> <p>3. R13's Minimum Data Set, dated dated dated [DATE] Section J1300 documents no for current tobacco use. R13's Smoking assessment dated [DATE] documents R13 as a non-smoker.</p> <p>On 12/7/24 at 3:15 PM, V4, Infection Preventionist/ Wound Nurse, confirmed the names on the smoking schedule as current smokers residing in the facility. V4 stated R13 was admitted as a non-smoker but did have a history of smoking and had picked up the habit since her admission. V4 stated R13 should have been re-assessed when she started smoking again.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34058</p> <p>Based on interview and record review, the facility failed to timely assess residents for risk of developing pressure ulcers, and to complete pressure ulcer treatments according to physician orders. These failures affect three residents (R4, R5, R6) out of three reviewed for wound care on the sample list of 24 residents.</p> <p>Findings include:</p> <p>1. On 12/6/24 at 2:30 PM, R6's Braden Scale assessment dated [DATE] was the most recent located in R6's Electronic Medical Record (EMR).</p> <p>R6's Treatment Administration Record (TAR) dated for November 2024 documents R6 had a physician ordered treatment for a pressure ulcer on the sacrum to be completed twice daily. This treatment was not documented as completed on 11/1/24, 11/11/24, 11/12/24, 11/14/24, 11/18/24 and 11/20/24. This TAR documents R6 had physician ordered ointment to be applied to R6's buttocks twice daily which was not documented as completed on 11/12/24, 11/14/24, 11/18/24, and 11/20/24. This TAR documents R6 had a physician ordered treatment to offload (elevate off the bed) R6's right heel which was nor documented as completed on 11/12/24, 11/14/24, 11/17/24, 11/18/24, and 11/20/24.</p> <p>R6's TAR dated for October 2024 documents R6 had a physician ordered treatment for a pressure ulcer on the sacrum to be completed twice daily. This treatment was not documented as completed on 10/7/24 and 10/28/24.</p> <p>2. On 12/6/24 at 11:28 AM, R5's Braden Scale assessment dated [DATE] was the most recent located in R5's EMR.</p> <p>R5's TAR dated for October 2024 documents a physician ordered pressure ulcer treatment for R5's sacrum to be completed from 10/8/24 through 10/14/24. This treatment was not documented as completed on 10/11/24. This TAR documents R4 is to receive physician ordered daily skin checks which was likewise not completed on 10/11/24.</p> <p>R5's TAR dated for September documents R5 had a physician ordered treatment for a pressure ulcer on the sacrum to be completed from 9/24/24 through 9/30/24 which was not documented completed on 9/27/24 and 9/29/24.</p> <p>3. On 12/5/24 at 10:30 AM, R4's Braden Scale assessment dated [DATE] was the most recent located in R4's EMR.</p> <p>R4's TAR dated for October 2024 documents R4 had a physician ordered treatments for pressure ulcers on the left outer ankle and sacrum each shift (twice daily). These treatments were not documented completed on 10/2/24 and 10/11/24.</p> <p>R4's TAR dated for November 2024 documents the treatment for R4's sacrum was not completed on 11/5/24 and 11/17/24.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/5/24 at 10:54 AM, V1, Administrator, stated that the facility policy for Braden Assessments is to do them on admission, weekly times four, then quarterly.</p> <p>The facility policy Braden Pressure Ulcer Risk Assessment Tool dated January 2017 documents these pressure ulcer risk assessments should be completed upon a resident's admission to the facility, weekly for one month, then at least quarterly, and with any significant change in condition.</p> <p>The facility policy Medication/ Treatment Administration Record (undated) documents the facility nursing staff are to promptly document each treatment administered in the record with the name and position of the administering personnel.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>34058</p> <p>Based on observation, interview, and record review, the facility failed to maintain door alarms and computer based door monitoring systems in functional condition to operate as designed. This failure has the potential to affect all 102 residents residing in the facility.</p> <p>Findings include:</p> <p>On 12/4/24 at 3:58 PM, V12, Maintenance Director, stated the facility utilizes a black box system connected through a centralized monitor screen located at the 400 hall nurses station. V12 stated the system is supposed to connect to additional monitors located at each of the facility's other three nurses stations on the 100, 200, and 300 halls. V12 stated the screen will display a floor map of the facility with each door of the facility located by a colored dot on the screen. V12 stated the system was not functioning to emit a sound when a door was opened.</p> <p>On 12/4/24 at 3:58 PM, the black box system monitor screen was black and not showing the floor plan on the screen. V12 manipulated some controls on the system and did get the screen to display the facility floor plan with green dots at each door location. There were two dots which turned red to indicate a door had opened but there was no audible alert activated.</p> <p>On 12/4/24 at 4:05 PM, V12 stated a staff member would need to be watching the screen to know that a door was opened and which door to go check. V12 stated he was not a tech guy and had been unable to fix the system.</p> <p>On 12/4/24 at 4:15 PM, the door leading into an outside courtyard from the small dining room did not have an audible alarm when the door was opened. This was the door where the residents would go outside to smoke, as observed on multiple occasions during the survey including 12/4/24 at 3:00 PM, and 12/7/24 at 1:00 PM. V12 pointed out a blue blinking light on the ceiling above the door and stated this was connected to the black box system and confirmed that a staff member would need to be present in the small dining room to see the light to know this door had been opened.</p> <p>On 12/4/24 at 4:20 PM, the black box door monitoring system monitor located at the 300 hall nurses station was black and not displaying the facility floor map. V12 attempted to manipulate some buttons on the side of the monitor, but the screen did not activate.</p> <p>On 12/4/24 at 4:25 PM, the double doors leading outside to a loading dock approximately four feet up from ground level and an associated ramp, had a small plastic sensor alarm which was non-functional. V12 stated the alarm was supposed to sound when the door was opened. The right side door opened with a simple push. V12 stated he had attempted to repair the alarm but would need to get someone else into the facility to repair it. V12 stated that the keypad at this door for the employees to enter a code to go outside had been disabled as well, and the only part of this door system that was functioning was the (electronic bracelet monitoring alarm). V12 confirmed that not every resident in the facility utilized a (electronic monitoring bracelet). During this tour of the facility doors, it was confirmed that the (electronic bracelet) monitoring alarms were functional.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/4/24 at 4:30 PM, the door leading to a second outside courtyard from the large dining room did not emit an audible sound when the door was opened. V12 stated no one every goes out that door. The door could be opened with a simple push.</p> <p>The door leading outside into a third courtyard from the activity room did not have an audible alarm when the door was opened. V12 stated there are always staff present in the activity room, however, there were subsequent multiple occasions of observing residents in the activity room engaged in coloring and cutting activities without staff present, including during scheduled resident smoking times when the activity staff was responsible for supervising the smoking residents.</p> <p>On 12/5/24 at 10:54 AM, V1, Administrator, stated she was aghast at the number of door alarms that were not functional. V1 stated that V12 and V13, Maintenance Assistant, were supposed to check the door alarms daily. V1 stated they needed some better communication so that as soon as there is a problem like that they can get someone to address it and get it fixed. V1 stated she told V12 the facility can not have things like this running half-as**d. V1 confirmed there is not always staff present in the activity room including during the scheduled resident smoking times and at night. V1 didn't know an exact number of residents who did not use (electronic bracelets) but estimated around 10 out of the current census of 102, and another 10 who were either bed bound or could not propel their own wheelchairs. V1 stated if V12 could not fix this black box system then he needed to get the company that installed it back here to fix it.</p> <p>On 12/5/24 at 12:40 PM, there was an audible announcement coming from the black box door monitoring system next to the 200 hall nurses station, door ajar. The monitor screen was black and the facility floor plan was not displayed. V9, Licensed Practical Nurse, V14 Certified Nursing Assistant, and V15 Certified Nursing Assistant, all stated they did not know which door was ajar or which door to go check because the screen wasn't working.</p> <p>On 12/5/24 at 12:53 PM, the black box door monitoring system next to the nurse station at the 300 hall had the same audible announcement door ajar, and the monitor screen was likewise black and not displaying the facility floor map. V8 Licensed Practical Nurse stated she did not know which door was ajar because the screen was not working. None of the aforementioned staff members made any effort to go check doors to locate if a door was actually open.</p> <p>The facility Resident Roster and Form 802 Resident Matrix, both dated 12/3/24, document 102 resident reside in the facility.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>34058</p> <p>Based on observation, interview, and record review, the facility failed to maintain dishwasher water temperatures at a level to sanitize dish wares. These failures have the potential to affect all 102 residents residing in the facility.</p> <p>Findings include:</p> <p>On 12/4/24 at 4:35 PM, V12, Maintenance Director, operated the facility dishwasher which reached a final rinse temperature of 156 degrees Fahrenheit (F). A second running cycle resulted in a final rinse temperature of 161 F, and a third cycle resulted in a final rinse temperature of 163 F.</p> <p>There was a metal plate on the front of the dishwasher directly below the digital temperature display which informed the user that the final rinse temperature must be 180 F to sanitize dish wares.</p> <p>On 12/5/24 at 10:18 AM, V21 was operating the facility dishwasher to wash the dishes from the residents' breakfast meal.</p> <p>V22, Dietary Manager, present upon request, stated that dishwasher is supposed to wash at a temperature of 150 F, and rinse at 180 F.</p> <p>The first observed cycle of the dishwasher resulted in a final rinse temperature of 168 F. A second and third cycle of the dishwasher resulted in final rinse temperatures of 177 F and 178 F, respectively.</p> <p>V22 stated the only thing she could do would be to serve residents on paper disposable plates and disposable plastic utensils until the dishwasher could be repaired.</p> <p>V12 stated he had called a service company but they would not be able to come to the facility until tomorrow morning (12/6/24). V12 stated he thought the dish machine had a bad solenoid.</p> <p>On 12/5/24 at 10:54 AM, V1, Administrator, stated she just became aware of the dishwasher failing to get hot enough to sanitize dishes. V1 stated there had to be better communication between V12, V22, and herself in order to get things fixed when there is a problem. V1 stated she had sent someone to obtain plastic wares and utensils to serve residents. V1 stated she was aware that the dietary staff could utilize the 3 compartment sink to wash, rinse, and sanitize dishes but that the staff did not want to do that because it took too long.</p> <p>The facility's Dishwashing Machine Manufacturer Specifications (undated) documents the final rinse temperature should be a minimum of 180 F.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 12/6/24 at 11:50 AM, V20, Dishwasher Service Company Technician, stated the facility had a contract with (competitor company) and it would be a breach of contract for him to service the facility dishwasher. V20 stated that with as busy as the service industry is at the present time, it would be unlikely that the (competitor company) would be able to get a service technician to the facility within the expected duration of this survey.</p> <p>The facility Resident Roster and Form 802 Resident Matrix, both dated 12/3/24, document 102 resident reside in the facility.</p>		

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<p>F 0850</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Hire a qualified full-time social worker in a facility with more than 120 beds.</p> <p>34058</p> <p>Based on interview and record review, the facility failed to provide the services of a qualified Social Worker for their facility with a bed capacity of 154. This failure affects all 102 residents residing in the facility.</p> <p>Findings include:</p> <p>On 12/17/24 at 11:50 AM, V1, Administrator, stated the facility does not have a Social Worker with a degree and has not had one for a long (undetermined) time. V1 stated the former Social Services Director (V31) does not have a degree. V1 stated as of this past Friday (12/13/24), V31 has been moved to the position of Business Office Manager and there was no one in the vacant Social Services position</p> <p>The facility's Illinois Department of Public Health License dated 12/10/23 documents the facility has a total skilled bed capacity of 154.</p> <p>The facility's current Staff Roster (undated) does not document any person in the position of Social Services. This Roster documents V31 as the Business Office Manager.</p> <p>On 12/18/24 at 8:55 AM, V31, Business Office Manager, stated he was formerly the Social Services Director, a position he started 10/28/24. V31 stated he began as the Business Office Manager on 12/10/24. V31 stated he has no bachelor's degree in Social Work nor in a Human Services Field. V31 stated the only supervision he had as the Social Service Director was a consultant who came to the facility for two hours on 11/10/24.</p> <p>The facility Resident Roster and Form 802 Resident Matrix, both dated 12/3/24, document 102 resident reside in the facility.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145422	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Fair Havens Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34058</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective pest control program by failing to control of dishwasher sewer surges of water, and sink drain sewer water leakage to prevent to infestation of pests. These failures have the potential to affect all 102 residents residing in the facility.</p> <p>Findings include:</p> <p>On 12/4/24 at 4:35 PM, V12, Maintenance Director, while operating the facility dishwasher, noted a live cockroach on the trash can next to the dishwasher. V12 smacked at the roach, knocking it to the floor, and stepped on the cockroach. There were also numerous small flying insects approximately three-sixteenths of an inch long with opaque wings, commonly referred to as sewer flies or fruit flies. These flies were hovering around the drains in the floor around the dishwasher, and along the stainless steel counters where soiled dishes were stationed prior to going through the dishwasher. and landed on the floor.</p> <p>The floor in the dishwasher area, approximately 12 feet by 12 feet square, was saturated with water. V12 stated the dishwasher sprays out water when the cycle starts. As V12 operated the dishwasher, a large [NAME] of water came out from under the dishwasher door in a spectacular fashion.</p> <p>There was a 2 compartment stainless steel sink directly adjacent to the stainless steel food preparation counters. The drain from the 2 compartment sink was leaking underneath both compartments of the sink, resulting in sewage water on the floor.</p> <p>On 12/5/24 at 10:18 AM, V22, Dietary Manager, stated she was aware of the flies and had noticed them especially around the floor drains and dishwasher drain. V22 stated the facility does have (pest control company) services. V22 further stated the kitchen staff try to keep the floor as dry as possible, and has chemicals to flush down the drain to try to eliminate the flies. V22 stated she had noticed, this past Monday (12/2/24) that the 2 compartment sink drains were leaking onto the floor and had turned in a maintenance work order.</p> <p>The facility's Resident Council Meeting Minutes dated from February 2024 documents resident complaints about fruit flies.</p> <p>The facility Resident Roster and Form 802 Resident Matrix, both dated 12/3/24, document 102 resident reside in the facility.</p>