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	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. (continued on next page)

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

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	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the dignity of two residents (R4, R2) out of two reviewed for dignity in a sample list of nine.Findings include:1) On 08/04/2025 at 2:30 PM, Employee handbook dated revised [DATE], documents on page 3: We count on you, our employees, to focus on the provision of quality care and excellent services for our residents and to do so with a high level of dignity, compassion, and responsiveness to their physical, medical, and emotional needs. Our residents deserve nothing less than your best each and every day. On 7/28/25, R4's record review documents a Minimum Data Set (MDS) completed on Jun 24, 2025, documents a Brief Interview for Mental Status (BIMS) score of 14. A score of 14 indicates R4 is cognitively intact.On 7/28/25, R4's Care plan record review documents an admission date of 08/25/2023 with diagnosis of Heart Failure, Non-st Elevation (nstemi) Myocardial Infarction, Acute Kidney Failure, Hypokalemia, and Type 2 Diabetes Mellitus without complications among others.On 7/24/25 at 12:30 PM, V15 CNA (Certified Nursing Assistants) reported that V1, Administrator, had thrown R4 out of the facility after roughly/rudely taking the silverware from R4's hand while R4 was taking a bite from the lunch plate. V15 stated V1 then pulled R4 from the table and took R4 to the front of the facility. On 7/28/25 at 2:35pm, V12 CNA stated that V2 [NAME] President of Operations had instructed all staff to pack R4's personal belongings. V1 was very unprofessional and snatched the fork from R4 while she (R4) was eating lunch. V15 stated that a garbage bag containing R4's personal belongings fell from the cart onto the ground, and V15 was instructed to leave it on the ground and to return into the building. V12 stated that R4 was taken into the facility van and R4 kept asking why she was leaving, and where she was going as R4 had not been told what was going on and why. 2) On 07/24/25 at 10:30am, R2 stated on 07/12/25 R2 activated his call light at 07:00am to get help from the nursing staff to get cleaned up and dressed for dialysis. R2 stated the transportation bus picks him up at 08:00am for dialysis. R2 stated two (2) certified nursing assistants (CNA) came into the room at 07:50am to get him ready for dialysis and were very hurried in trying to get him ready for the bus. R2 stated he made the bus and went to dialysis, upon completion on his dialysis treatment R2 stated he smelled something on himself and was now upset because he does not like being dirty or smelling. R2 stated that he asked the dialysis nurse if she smelled something, she replied yes, she does. R2 stated he asked the bus driver if he smelled something, R12 stated the bus driver stated he did when the bus driver leaned over to secure the wheelchair. R2 stated he was humiliated and did not talk during the ride from the dialysis center to the facility. R2 stated that upon arriving back to the facility he asked the staff to lay him down and help him get cleaned up, to which the second shift CNAs did. Upon opening up the incontinence brief, the CNA behind him exclaimed Oh my God and held up a washcloth she stated was from inside the brief and causing the odor. R2 stated he was humiliated at the smell and could not believe someone left a washcloth in his brief. On 7/24/25 at 12:00 pm, V8, LPN (License Practical Nurse), stated that she was the nurse on duty on 7/12/25 and sometime in the afternoon a CNA reported to her that when providing cares to R2 and when the CNA removed the brief there was a washcloth in the brief. V8 stated that R2 was very mad and upset and refused an assessment of the area and wanted to be left alone. On 07/24/25 at 1:48pm, V11 CNA stated when R2 returned from dialysis R2 requested help in getting cleaned up due to having a smell from his body. V11 stated R2 was transferred to the bed via the total mechanical body lift, rolled over and removed the brief and discovered a wet washcloth in the skin fold between the gluteus maximus (butt cheeks). V11 stated R2 was very upset at the smell and that a washcloth was left inside the brief. V11 stated R2 requested to be left alone once cares were completed. On 08/04/2025 at 2:30 PM, Employee handbook dated revised [DATE], documents on page 3: We count on you, our employees, to focus on the provision of quality care and excellent services for our residents and to do so with a high level of dignity, compassion, and responsiveness to their physical, medical, and emotional needs. Our residents deserve nothing less than your best each and every day.

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	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect one resident (R11) from verbal abuse for one of three residents reviewed for verbal abuse on a sample list of nine.Findings Include: Facility Abuse Prevention Program policy effective 10/2022, documents this facility affirms the right of their residents to be free from abuse, neglect, exploitation, misappropriation of property, and deprivation of goods and services. This policy documents abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. The same policy documents 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, saying things to frighten a resident. The policy documents as part of the resident's life history on the admission assessment, comprehensive care plan, and MDS assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment, history of trauma or misappropriation of resident property, who have needs, triggers and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property for these residents. Staff will continue to monitor the goals and approaches on a regular basis and update as necessary.R2's Clinical Census, undated, documents an original admission date of 8/31/23. Minimum Data Set completed on July 23, 2025, documents a Brief Interview for Mental Status (BIMS) score of 12 of 15. A score of 12 indicates R2 has moderate cognitive impairment.R2's Care plan dated 09/01/2023 documents diagnosis of: End Stage Renal Disease, Essential (Primary) Hypertension, Hereditary and Idiopathic Neuropathy, Paraplegia. The same care plan documents: Usual ADL (Activities of Daily Living) Performance: R2 is independent for eating with set up help. Max A (maximum assistance) of one to two is needed for personal hygiene, dressing, toileting & bed mobility, and is dependent with transfers with a total body mechanical lift of two.R11's Clinical Census, undated, documents an original admission date of 5/8/2025. Minimum Data Set completed on May 14, 2025, documents a Brief Interview for Mental Status (BIMS) score of 15 of 15. A score of 15 indicates R11 is cognitively intact.R11's Care plan dated 05/21/2025 documents diagnosis of Alcohol Abuse, Calculus of Gallbladder without Cholecystitis without Obstruction, Hypertensive Heart Disease without Heart Failure, Hypothyroidism, Gastro-Esophageal Reflux Disease without Esophagitis, Hyperlipidemia, Peripheral Vascular Disease, Essential (primary) Hypertension, Pain in Right Wrist, Osteoarthritis, Alcohol Dependence with Alcohol-Induced Persisting Dementia.On 8/11/25 at 10:30am, R2 stated that he received a new roommate (R11) on 8/8/25, with whom R2 stated he did not get along with. R2 stated R11 wanted the room dark, curtains pulled and R11 turned up the television really loud. R2 stated R11 began cussing R2 so R2 began yelling and threatened to beat up R11 with bodily injury.On 8/11/25 at 10:45am, R11 stated his belongings were moved to room [ROOM NUMBER] without his knowledge on 8/8/25 and that R2 had yelled at R11 and R2 threatened R11 with bodily injury.On 8/13/25 at 11:43am, V32, housekeeper, stated she was at the nurse's station and heard R2 and R11 yelling at each other and heard R2 threaten R11 with bodily harm. V32 stated staff went to room [ROOM NUMBER] and moved R11 back across the hall to room [ROOM NUMBER]. V32 stated R11 has had multiple residents and is hard to get along with.

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	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to remove a washcloth from the adult incontinence brief after cares were provided. This failure resulted in R2 experiencing a foul odor causing R2 to feel humiliated and embarrassed while in public. R2 was one of three residents reviewed for quality of care on a sample list of nine.Findings include:On [DATE] at 2:30PM, Employee handbook dated revised [DATE], documents on page 3: We count on you, our employees, to focus on the provision of quality care and excellent services for our residents and to do so with a high level of dignity, compassion, and responsiveness to their physical, medical, and emotional needs.R2's Clinical Census, undated, documents an original admission date of [DATE]. Minimum Data Set completed on [DATE], document a Brief Interview for Mental Status (BIMS) score of 12 of 15. A score of 12 indicates R2 has moderate cognitive impairment. R2's Care plan dated [DATE] documents diagnosis of: End Stage Renal Disease, Essential (Primary) Hypertension, Hereditary and Idiopathic Neuropathy, Paraplegia. The same care plan documents: Usual ADL (Activities of Daily Living) Performance: R2 is independent for eating with set up help. Max A (maximum assistance) of one to two is needed for personal hygiene, dressing, toileting & bed mobility, dependent with transfers with a total body mechanical lift of two. On [DATE] at 10:30am, R2 stated on [DATE] R2 activated his call light at 07:00am to get help from the nursing staff to get cleaned up and dressed for dialysis. R2 stated the transportation bus picks him up at 08:00am for dialysis. R2 stated two (2) certified nursing assistants (CNA) came into the room at 07:50am to get R2 ready for dialysis and were very hurried in trying to get him ready for the bus. R2 stated R2 made the bus and went to dialysis, upon completion on his dialysis treatment R2 stated he smelled something on himself and was now upset because he does not like being dirty or smelling.R2 stated that he asked the dialysis nurse if she smelled something, she replied yes, she does. R2 stated he asked the bus driver if he smelled something, R12 stated the bus driver stated he did when the bus driver leaned over to secure the wheelchair. R2 stated he was humiliated and did not talk the ride from the dialysis center to the facility.R2 stated that upon arriving back to the facility he asked the staff to lay him down and help him get cleaned up, to which the second shift CNAs did. Upon opening up the incontinence brief, the CNA behind him exclaimed Oh my God and held up a washcloth she stated was from inside the brief and causing the odor.R2 stated he was humiliated at the smell and could not believe someone left a washcloth in his brief.On [DATE] at 12:00 pm, V8 LPN (License Practical Nurse), stated that she was the nurse on duty on [DATE] and sometime in the afternoon a CNA reported to her that when providing cares to R2 and the CNA removed the brief there was a washcloth in the brief. V8 stated that R2 was very mad and upset and refused an assessment of the area and wanted to be left alone.On [DATE] at 12:35pm, V9 CNA stated she was told there was a washcloth in the incontinence brief, but unsure how that happened.On [DATE] at 1:38pm, V10 CNA stated she assisted V9 CNA in getting R2 ready for dialysis but R2 was very upset and yelling at staff. V10 stated she was told there was a towel in the brief but does not know how it got there.On [DATE] at 1:48pm, V11 CNA stated when R2 returned from dialysis R2 requested help in getting cleaned up due to having a smell from his body. V11 stated R2 was transferred to the bed via the total mechanical body lift, rolled over and removed the brief and discovered a wet washcloth in the intergluteal cleft, (skin fold between the buttocks). V11 stated R2 was very upset at the smell and that a washcloth was left inside the brief. V11 stated R2 requested to be left alone once cares were completed. Example 2Based on interview and record review the facility failed to notify the primary care physician of a change in condition when the onset of multiple episodes of diarrhea began for one (R7) of three residents reviewed for death on the sample list of nine.1 This failure resulted in R7 having multiple episodes of untreated diarrhea for eight consecutive days. Findings Include:On [DATE] at 11:30 AM, Record review of Notification of Resident Change in Condition Policy, Undated, states: It is the policy of this facility to promptly notify the resident, their legal representative and attending physician of changes in the resident's health condition. The same document states under Standards: 2. The licensed nurse is to use professional judgment in determining changes in condition based on assessment and findings or signs and symptoms of change which could lead to deterioration if not treated. 3. Clinical change in condition is determined by resident visualization, medical record review, clinical assessment findings and care plan review. Review of high-risk clinical issue such as skin breakdown, falls, weight loss, dehydration and others are conducted on a daily basis. 7. Changes in the resident's condition will be communicated to the direct care staff by verbal shift-to-shift report, revision in resident assignments

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	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure hot food was served to for three residents (R1, R2, R3) out of three reviewed for dietary services in a sample list of nine.Random observations were completed on 7/24/25 through 8/4/25 related to dietary services, during observations the hall tray cart was delivered to the hallway and nursing staff would deliver trays to the residents. The trays contained the afternoon meal on a plate with a cover. No hot plate under the ceramic plate to keep the food warm. The trays also contained cold food and the drinks. On 7/24/25 at 12:00 PM, the lunch food cart was delivered to the 300 hall by kitchen employee, nursing staff did not pass the trays for 12 minutes to residents. On 8/4/25 at 12:07pm the lunch cart was delivered to the 300 hall, nursing staff passed the meals from the cart at 12:18pm. R1's Clinical Census, undated, documents an original admission date of 4/14/22. Minimum Data Set completed on [DATE], documents a Brief Interview for Mental Status (BIMS) score of 13. A score of 13 indicates R1 is cognitively intact.R2's Clinical Census, undated, documents an original admission date of 8/31/23. Minimum Data Set completed on July 23, 2025, documents a Brief Interview for Mental Status (BIMS) score of 12 of 15. A score of 12 indicates R2 has moderate cognitive impairment. R3's Clinical Census, undated, documents an original admission date of 1/21/25. Minimum Data Set completed on July 1, 2025, documents a Brief Interview for Mental Status (BIMS) score of 14. A score of 14 indicates R3 is cognitively intact. On 7/24/25 at 10:00am, R1 stated the food always arrives cold. R1 stated R1 has told staff about the cold food before. On 7/24/25 at 10:05am, R3 stated the food is delivered cold and often tasteless. R3 stated that R3 has asked staff to warm her food in a microwave to warm it up.On 7/24/25 at 10:15am, R2 stated the food is not very good or warm and R2 often eats out especially on dialysis days. On 7/24/25 at 12:22pm, R1 stated the lunch food on R1's plate is cold.On 7/24/25 at 12:25pm, R3 stated the food was cold. On 8/4/25 at 12:30pm, R1 stated the lunch was cold and bland. On 8/4/25 at 12:33pm, R3 stated R3's lunch plate was cold. On 8/4/25 at 12:35pm, R2 stated he did not eat the lunch because it was cold and didn't taste good. On 8/5/25 record review of Resident Council minutes dated 4/24/25 documents the residents stated the food is cold. Resident Council minutes dated 5/26/25 document the residents stated the food is cold.