

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 09/02/2025
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to provide timely incontinence care for a resident dependent on staff for hygiene. This failure affects one (R7) of three residents reviewed for Activities of Daily Living in the sample list of eleven. Findings include: The facility's Policy and Procedure: Call Light System (undated) documents it is the policy of this facility to provide a means of communication to meet the needs of each resident. Staff will follow established procedures to respond to the resident's requests and needs. Procedure: Respond promptly when the call light is activated. Identify self, determine the resident's need and turn off the call light. Respond to the residents needs or request and if unable to meet the need, find the staff member who can meet the need. R7's Face Sheet (9/2/25) documents R7 has the following diagnoses: Paraplegia, lack of coordination, weakness, and need for assistance with personal care. R7's Quarterly Assessment (7/23/25) documents R7 is cognitively intact, has bilateral lower extremity impairment, and dependent on staff for toileting. R7's Care Plan (current) documents R7 is at risk for ADL (activities of daily living) self-care deficiency and requires staff assistance with personal hygiene, dressing, toileting, and bed mobility. Further documents encourage and assist in using the restroom upon rising/before bed, before/after meals, and upon request in order to promote current level of bowel continence and decline. R7's Bowel Movements and Continence Point of Care Task does not document any incontinence cares provided to R7 on 8/25/25. On 8/29/25 at 1:28pm, R7 stated in the early morning of 8/25/25, R7 asked the CNA (V15 Certified Nursing Assistant) to clean R7 up and was told they would be back to help. R7 stated could hear V15 in another room talking for around 45 minutes while R7 sat in feces. R7 stated R7 advised multiple staff [V8 Registered Nurse, V14 CNA, and V15] that R7 was dirty and needed cleaned up. R7 stated day shift (the next shift) cleaned R7 up. On 9/2/25 at 10:59am, V3 Wound Nurse stated staff should have changed R7 instead of just leaving R7's room to go finish getting other residents up for the day. V3 stated staff need to prioritize cares better. On 9/2/25 at 11:31am, V14 CNA V14 stated it was overnight shift on Sunday 8/24/25 into Monday 8/25/25, R7's call light was on and V14 answered it. V14 stated, I checked on [R7] to see if there was something I could do for [R7]. R7 stated R7 had been waiting 45 minutes for V15 to return. V14 stated V14 advised V15 of R7 waiting on V15. V14 stated V14 and V15 entered R7's room and R7 asked V14 to clean R7 up. V14 stated V15 interjected stating we had to finish getting this other resident up first. V14 stated R7 cursed at V15 telling V15 to take *** (expletive) out of here. V14 stated they both walked out at that time. V14 stated V14 went to finish getting residents up and V15 went to talk with the nurse (V8). V14 confirmed neither cleaned R7 up at that time. V14 stated went back into R7's room with V8 RN and they both exchanged words. V14 stated R7 said some things R7 shouldn't have said to staff but R7 can be that way. V14 stated R7 requested again to be changed at that time, but R7 did not get changed at that time. On 9/2/25 at 12:38pm, V8 RN stated V8 went to answer R7's call light to see what the problem was. V8 stated V8 was in the middle of morning medication pass and the two aides were getting residents up for the day. V8 stated V8 advised R7 to not cuss out staff. V8 stated R7 stated R7 wanted to get up and was dirty. V8 stated, I told [R7] I was going to find someone to help and would be back as soon as I can. V8 stated V8 advised oncoming nurse of R7's behaviors (cussing out staff) and then went to finish medication pass. V8 stated, I don't know if [R7] was changed. My shift ends at 6am and at that point (after finishing medication pass) my shift was over. V8 stated, I don't know what time they got to change [R7].</p>		