

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 12/02/2025
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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (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
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed repeatedly, to provide a dependent resident (R7) showers. R7 is one of six residents reviewed for Quality of Care on the sample list of 35. Findings include:R7's Minimum Data Set (MDS) dated [DATE] documents R7's Brief Interview of Mental status score of nine out of a possible 15, indicating severe cognitive impairment. The same MDS documents R7 had no hallucinations or delusions, and no behaviors verbal or physical towards self or others and has not rejected care during the lookback period of this assessment.The same MDS documents R7 has occasional incontinence of urine and is continent of bowel.The same MDS documents R7 requires Substantial/maximal assistance - Helper does 'MORE THAN HALF' the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. (for) Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment. (and) Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.R7's November 2025 shower sheet lists individual lines and a body map to record the date, time, and any skin impairment when resident showers occurred. R7's shower sheet is blank.On 11/23/25 at 6:00 am V30, Certified Nursing Assistant (CNA) stated I do know, (R7) does refuse her showers at times. She (R7) is a second shift shower (scheduled to receive a shower). She can be stubborn at times and other times she will let us give her one. We just reapproach her later that day. I can show you the shower book. V30, CNA got the shower book from the nurse's station and turned to R7's November 2025 showers sheet record. V30 stated It does not look like she has had a shower all month. She is supposed to get one twice a week. All residents get a shower twice a week. Even if a resident refuses, it is documented in this book, and a sheet it is supposed to be made up (documented). The sheet is given to the nurse to sign off. There is nothing on her page (documented in the shower book) at all. It should list if a bed bath was given instead. There is nothing documented. I would say from this, (R7) did not get a shower. As I said she has Alzheimer's. She would never ask for one (a shower). When I have (take care of) her, I clean her up good, so she does not have incontinent odors. It has been a while since I have given her a shower.On 11/23/25 at 6:35 am R7 stated she can't remember the last time she took a shower. R7 also stated I hope I am on the list to get one. I need to be fresh every day.On 11/23/25 at 7:25 am V2, Director of Nursing (DON) stated I can see (R7's) shower sheet (page in shower book) for November (2025) does not document (R7) had any showers. It does not look like she got showers, but it may be just a failure to document. The CNAs should be documenting if (R7) refuses. There are no showers or refusals documented for (R7), therefore, there would not be any follow-up. If the sheets aren't completed and given to the nurse, we have no way of knowing (that showers weren't given).On 11/26/25 at 1:00 pm V14, R7's Family Member stated (R7) has not been getting showers. She has strong odors of urine, when I come to visit. I have brought it to their (unidentified facility staff) attention on several occasions. Staff tell me she refuses. I have asked them to let me know and I will talk to her. That was about three weeks ago. I have not had a phone call. I figured she was getting them. The next time I came (to the facility), she had the same odor. (R7) said she knows she needs a shower, but staff are too busy. When I left, I mentioned (R7) wanted a shower. Whoever the nurse (unidentified) was said she would make sure she got one that day.The facility policy Shower /Tub Bath dated as revised August 2002 documents the following: The purpose of this procedure is to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to complete a physician ordered wound treatment for one (R4) of three residents reviewed for treatments in the sample list of 35. Findings Include: The Undated MEDICATION/TREATMENT ADMINISTRATION RECORD POLICY documents It is the policy of this facility that each medication/treatment administered will be promptly documented in the medication record after administration. The policy documents the purpose is to validate residents are receiving drugs and biologicals as ordered by the physician. 9. Documents Nursing personnel administering medication/treatments will abide by all Medical Records Policies. R4's care plan documents R4 admitted to the facility on [DATE] with diagnoses of Fracture of Right Femur, Chronic Ulcer of Other Part of Right Lower Leg, Chronic Ulcer of Other Part of Left Lower Leg, and Abnormalities of Gait and Mobility. On 11/19/25 at 1:40pm R4 was laying in the bed with covers over the bilateral legs. On 11/19/25 at 1:45pm R4 stated the wound dressing changes had not been completed to both of R4's knees on this day. R4 stated the dressing changes are to be completed twice daily. R4 removed covers from both legs. R4 stated the night nurse completed the wound dressing changes to the knees at about midnight the night before. On 11/19/25 at 1:50pm R4's wound dressings to bilateral knees were dated 11/18/25 at 12:00 AM and initialed by V12 Licensed Practical Nurse (LPN). Both dressings were overly saturated with Serosanguinous drainage. The drainage had soaked through the bandage and out onto pillowcases and towels R4 had placed under the knees to absorb the drainage. The added laundry was also saturated and leaked onto the bed. R4 stated this is common for the dressings to be overly saturated and not completed twice daily. On 11/19/25 at 1:59pm record review of the Treatment Administration Record documents V8 completed the wound dressing change on 11/19/25 at 09:00am. Record review of the Treatment Administration Record documents a physician order of Gentamicin Sulfate External Cream 0.1 % (Gentamicin Sulfate (Topical)) Apply to left knee topically two times a day (09:00am and 09:00pm) related to NON-PRESSURE CHRONIC ULCER OF OTHER PART OF LEFT LOWER LEG WITH FAT LAYER EXPOSED. On 11/19/25 at 02:10pm V8 Registered Nurse was observed with the treatment cart outside of R4's room preparing to complete the treatment/dressing changes for R4. On 11/19/25 at 2:14pm V6 LPN/Wound Nurse confirmed the wound dressing on R4's right and left knee are overly saturated and leaking onto the added linen and bed. V6 confirmed the date on the wound dressings as 11/18/25. V6 confirmed the physician order documents the dressings are to be completed at 09:00am/pm. V6 stated the physician order should not have a specific time but should be timed to be completed throughout the shift at some point. V6 confirmed V8 should not have signed the Treatment Administration record until the treatment had been completed.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</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 - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide supervision during a shower (R19) and failed to provide supervision outside during smoking (R7) which resulted in falls. R19 and R7 are two of three residents reviewed for falls on the sample list of 35. Findings include: 1.) R19's current diagnoses sheet documents the following: Difficulty [NAME], Not Elsewhere Classified, Muscle Weakness (Generalized), Other Lack of Coordination, Need for Assistance with Personal Care and Repeated Falls. R19's Minimum Data Set (MDS) dated [DATE] documents the following: R19's Brief Interview of Mental Status (BIMS) score as 15 out of a possible 15, indicating R19 has no cognitive impairment. The same MDS documents R19 has had two falls with no injury and one fall with minor injuries since the last MDS assessment. R19's Fall-Incident report dated 9/20/25 documents R19 had an unwitnessed fall in the shower. Root cause on the report was determined to be: R19 slipped when standing up from the shower chair. The intervention was documented as follows; Staff to ensure they stay in the shower room with the resident until shower is completed. On 11/25/25 at 12:15 pm R19 talked about falls in the facility and with this surveyor which included on 8/25/25 he forgot to lock his brakes on the walker when standing up on the smoking patio, and 9/14/25 he had a seizure and fell at the front desk. R19 then stated I was left in shower for a different fall, I believe in September or October (confirmed above, 9/20/25). A CNA (unidentified Certified Nursing Assistant) was coming in to give another resident, I don't know, a shower. There I laid on the floor. I hit my head, so I am not sure how long I was out. I slipped on the floor trying to get dressed, after I finished my own shower. That is it in a nutshell. That CNA that took me in the shower room, just left me by myself. Totally forgot about me. On 11/25/25 at 1:45 pm V3, Assistant Director of Nursing (ADON) confirmed she completes the fall investigations in the facility. V3 reviewed R19's falls and confirmed R19's falls which included the 9/20/25 fall in the shower. V3, ADON stated R19's fall was unwitnessed because a CNA (unidentified) had left him unattended in the shower and shouldn't have. 2.) R7's current diagnoses sheet documents Unspecified Dementia, Unspecified Severity Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. R7's Fall Risk Assessments dated 7/15/25, 7/21/25, 8/1/25, 8/16/25, 9/22/25 and 10/20/25 all document fall risk scores of greater than then 10, indicating R7 is and has been consistently at a high risk for falls. R7's Minimum Data Set (MDS) dated [DATE] documents R7's Brief Interview of Mental status score of nine out of a possible 15, indicating severe cognitive impairment. The same MDS documents R7 had no hallucinations or delusions, and no behaviors verbal or physical towards self or others and has not rejected care during the lookback period of this assessment. R7's Smoking Assessment dated 07/15/25 documents R7 requires supervision while smoking. R7's Fall-Incident report dated 10/21/25 documents R7 went outside to obtain a cigarette from another resident (R9) and R7 stepped into a groove on the side of the walkway which resulted in a fall. The root cause was (R7) lost balance on uneven pavement. This same incident report documents the fall was witnessed by R9. R7's Care Plan updated 10/21/25 documents the following: (R7) is at risk for falls r/t (related /to) Deconditioning, Gait/balance problems, Unaware of safety needs, Vision/hearing problems. The same care plan documents the following intervention update 10/21/25. Encourage (R7) not to go into the courtyard unattended. On 11/21/25 at 11:25 am R9 was in her wheelchair on the smoking patio. R9 stated (R7's) fall. I saw her walker got caught on the edge of the sidewalk, right there (R9 points to the sidewalk, which had a two inch drop off to the ground), by the flower beds. I said to (R7), you need to move your walker. I turned my head and the next thing you know, she was on the ground. I (R9) turned my head back and her (R7's) head was all the way down into the flower bed. I went immediately or as fast as I could in a wheelchair. I caught a nurse (unidentified nurse) and told her (R7) fell and they (unidentified staff) were right out here. There was no staff around when (R7) fell. I had to look for a few minutes. It's sad, really. (R7) wanders a lot outside. On 11/25/25 at 1:45 pm V3, Assistant Director of Nursing (ADON) stated (R7) is not and has not been an independent smoker. She wanders out on the patio. She must have a staff member with her. (R7's) fall occurred outside on the smoker's patio, unsupervised by staff and (R7) fell on uneven pavement. Her fall was witness by (R9) who summoned the nurse. (R7) was evaluated and had no injuries. 72-hour observations were completed according to policy and supervision when smoking was the intervention to prevent further incidents. The facility policy Resident Smoking Policy and Contract dated 05/22/23 documents the following: Some residents may require more intensive supervision while smoking. These residents smoke separately from other residents, under supervision of a</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain a urinary indwelling catheter tube in a secure manner, to prevent pain for one of three residents (R1) reviewed for indwelling urinary catheters on the sample list of 35. Finding include: R1's Physician Order Sheet dated 11/1/25-11/30/25 documents the following: (Name brand - indwelling urinary catheter) Catheter French (type):16F Balloon Size:10cc (cubic centimeters) Dx (diagnosis): Obstructive and Reflux Uropathy. R1's Minimum Data Set (MDS) dated [DATE] documents R1's Brief Interview of Mental Status score of 13 out of a possible 15, indicating R1 has no cognitive impairment. The same MDS documents R1 has a urinary indwelling catheter. R1's Care Plan dated 8/25/25 documents the following: (R1) has indwelling Catheter r/t (related/to) dx (diagnoses) obstructive reflux uropathy, urinary retention and is at risk for UTI (Urinary Tract Infection) with HX (history) of UTI. The same Care Plan documents: (R1) will be/remain free from catheter-related trauma through review date. (Target Date: 11/27/2025). On 11/23/25 at 5:50 am V32, Certified Nursing Assistant (CNA) entered R1's room to assist R1 with peri-care/catheter care. There was no date on the urinary indwelling catheter tubing or drainage bag. Urine is straw colored, no sediment noted in bag or tubing. R1 did not have a security leg strap to prevent pulling on the catheter meatus insertion site. R1's cloth linen saver pad was under R1's buttocks. The linen saver pad was moderately wet and had soaked through to R1's bedsheet. R1's fitted sheet had an approximately eight inch sized mildly wet area. V32, CNA confirmed the urine had leaked from R1's urinary catheter. V32 CNA stated I will have to get you cleaned up and find a strap to hold this (indwelling urinary catheter) in place. I will let the nurse know you're having pain. R1 stated I am in pain from this catheter. It feels like it is going to rip the skin around my private parts and pull the catheter right out (exit the bladder). I have never had a leg strap to keep it in place. I did not know there was such a thing. Now that I know that might work, I would like that. I need that. They don't even tape it (urinary catheter) to prevent it from coming out now. I have asked them to tape it, several times. It hurts so bad sometimes. I pee around the catheter and soak my bed. I hate that. I hate laying in my own pee. The nurses have never changed the catheter (medical records document monthly changes). I have had this thing (urinary indwelling catheter) in me since September 12, 2025. They are supposed to change it every month. The nurses don't listen to me. I have told them that for well over a month. The CNAs (Certified Nursing Assistants) change this pad under me at least once a day because the catheter (urinary indwelling) leaks so much. The facility policy Foley Catheter Insertion, Female Resident dated as revised August 2008 documents the following equipment/supplies needed for indwelling urinary catheter insertion include (number 19) adhesive tape. The same policy documents steps in the procedure (number 21) Attach catheter to the drainage tubing. Tape catheter to inner thigh or secure with leg band.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to maintain a Schedule IV, Controlled substance medication supply in a timely manner for one of sixteen residents (R13) reviewed for medication on the sample list of 35. Findings include:R13's current Diagnoses Sheet documents the following: Schizoaffective Disorder, Unspecified, Major Depressive Disorder Recurrent, Severe with Psychotic Symptoms, Generalized Anxiety Disorder, Auditory Hallucinations, and Insomnia.R13's Physician Order Sheet dated September 1-31, 2025, documents the following medication order: Lunesta (hypnotic, controlled substance) Oral Tablet 2 MG (Eszopiclone), Give 1 tablet by mouth at bedtime related to Schizoaffective Disorder, Unspecified.R13's Minimum Data Set, dated [DATE] documents R13's Brief Interview of Mental Status score as 15, out of a possible 15, indicating R13 has no cognitive impairment.R13's Administration note dated 9/24/2025at 12:09 am, documents the following: Note Text: Lunesta Administration Oral Tablet, 2 MG (milligrams), Give 1 tablet by mouth at bedtime related to Schizoaffective Disorder, Unspecified. Waiting on pharmacy.R13's Nursing Note dated 9/24/2025 at 09:37 am, documents the following: Note Text: Writer contacted (Private) Behavioral Center regarding resident needing new script for Lunesta. Message left for nurse.R13's Nursing Note dated 9/24/2025 at 10:03 am, documents the following: Note Text: Return call made and communication was sent to (R49 Psychiatrist) for Lunesta refill.R13's Administration note dated 9/24/2025 at 7:17pm documents the following: Note Text: Lunesta Oral Tablet 2 MG Give 1 tablet by mouth at bedtime related to Schizoaffective Disorder, Unspecified. Waiting on script.R13's Nursing Note dated 9/28/2025 at 8:21 pm documents the following: Note Text: psych MD (unidentified Psychiatric Physician) still has not sent script for Lunesta, writer and primary nurse have called (Private Psychiatric Company) for new script, (V4, Medical Director) notified new order for Melatonin 3mg po at hs (bedtime) prn (as needed) for Insomnia. Resident (R13) aware.R13's Controlled Drug Receipt/Record/Disposition Form dated 8/21/25 documents the facility pharmacy delivered 30 tablets, of Eszopiclone (Lunesta generic) 2 milligram. The same form documents a blank on 9/16/25 and a line is drawn through the entry 9/18/25. R13's last two doses of Lunesta were documented on this same form as sent with R13 on a home visit 9/20/25.R13's Controlled Drug Receipt/Record/Disposition Form dated 9/16/25 documents the facility pharmacy delivered 2 tablets, of Eszopiclone (Lunesta generic) 2 milligram. The same form documents the 9/16/25 and 9/18/25 doses that were missing from that above form, were given.There are no other Controlled Drug Receipt/Record/Disposition Forms until R13's Lunesta was increased to 3 milligrams documented below. R13's Physician order Sheet dated October 1-31, 2025, documents an increased in dose of R13's Lunesta (Eszopiclone) Oral Tablet 3 milligrams), Give 1 tablet by mouth at bedtime, related to Schizoaffective Disorder, Unspecified, start date 10/01/25.R13's next Controlled Drug Receipt/Record/Disposition Form dated 10/02/25 documents the facility pharmacy delivered 30 tablets of Eszopiclone (Lunesta generic) 3 milligram tablets, which reflects an increased dose as ordered by V48, Psychiatric Nurse Practitioner 10/1/25. The pharmacy delivery sheet documents reflect the same quantity of Lunesta was delivered as the Controlled Drug Receipt/Record/Disposition Form above. There were no deliveries of R13's Lunesta between 9/20/25 when last dose signed out, depleting supply on hand, until the new prescription of Lunesta 3 milligrams was delivered on 10/2/25. R13's September Medication Administration Record between 9/21/25 and 9/30/25 documents the number nine indicating to see nurse notes, or number one indicating Lunesta was sent out on a home visit or signed off by the nurse indicating Lunesta had been administered though the controlled substance supply on hand had been exhausted.On 11/25/25 at 2:20 pm R13 stated My real concern is my medication. I need this medication to think straight. I need this medication to sleep good at night. The yellow one, or maybe the blue one, I get at 7:00 pm. It was a couple months ago that a nurse told me that my pills did not come in from the pharmacy. My daughter (unidentified) went to the old Administrator at the time and told them my medication was not given. It was several days; I went without those pills. They had to get me Melatonin (non-controlled substance hypnotic medication) until my Lunesta could get refilled. It worked ok, but not as well as my Lunesta. That (Lunesta), I can sleep all night and clear my thought.On 11/26/25 at 12:15 pm V5, Minimum Data Set/Care Plan Coordinator/Licensed Practical Nurse (LPN) reviewed R13's Nurses Notes. V5, LPN stated (R13's) Lunesta required a signed prescription to get it filled. It is considered a controlled substance. (Private Company) Psychiatric Physicians (unspecified) will order residents medications then fail to provide the signed prescription. That was the case with (R13) Lunesta. The</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to administer medication as ordered by the physician for one (R4) of 17 residents reviewed for medication administration in a sample list of 35.R4's care plan documents R4 admitted to the facility on [DATE] with diagnoses of Fracture of Right Femur, Chronic Ulcer of Other Part of Right Lower Leg, Chronic Ulcer of Other Part of Left Lower Leg, and Abnormalities of Gait and Mobility.On 12/2/25 at 10:30am record review documents on 10/23/2025 at 2:15pm a physician's order was obtained for Hydromorphone HCl (pain) Oral Tablet 4 MG. Directions are to give 1 tablet by mouth every six hours as needed for pain.On 12/2/25 at 10:45am Record review of the Controlled Drug Receipt/Record /Disposition form documents R4 was administered on the following dates and times at less than six-hour intervals: 11/1/25 at 9:00am and 2:00pm (5hours apart), 11/2/25 at 2:00pm and 2:30pm (30min apart), 11/3/25 at 7:00pm and 11:15pm (4hours 15min apart), 11/4/25 at 09:13am and 1:00pm (3hours and 45min apart), 11/7/25 at 09:00am and 1:30pm (4hours and 30min apart), 11/8/25 at 7:00pm and 11:50pm (4hours and 50min apart), 11/15/25 at 08:00 and 12:00pm (4 hours apart), 11/17/25 at 8:00am and 1:00pm (5hours apart), 11/20/25 at 10:00am and 1:15pm (3hours and 15min apart), and 11/21/25 10:00am and 12:00pm (2hours apart).On 12/2/25 at 11:00am V2 Director of Nursing and V43 Corporate Clinical Education confirm the physicians order stated for the Hydromorphone to be given every six hours as needed for pain. V2 and V43 reviewed and confirmed the Controlled Drug receipt/Record /Disposition form documents R4 was administered the medication on the various days at intervals less than six hours as ordered by the physician.</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 12/02/2025
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 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>(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>Based on observation, interview and record review the facility failed to maintain a clean, safe, sanitary environment to prevent cross contamination of food service areas and cooking utensils, free of German cockroach infestation. This failure has the potential to affect all 95 residents that reside in the facility. Findings include: On 11/21/25 at 1:50 PM V26, Housekeeper/Laundry stated We clean the rooms (resident rooms) every day and as needed. There have been bugs in residence rooms on occasion. That is not the issue. The issue is the kitchen and dining room. Let me show you the staff lounge. That wall backs up to the kitchen and is just adjacent to the steam table line where all the resident's food is plated (confirmed observation of staff lounge location). I haven't heard any resident complain that they had a bug in their food. But I can tell you they complain about bugs in the dining room, often. Walk down here and I can show you the staff lounge. You won't believe it. V26 Housekeeper entered the staff lounge door which was directly next to the steam table food service line. There were copious amounts of bugs, too many to count. Living and dead bugs were under the radiator that spanned approximately eight feet along the floors edge, on top of the radiator, all the way around the edges of the floor, under staff lockers and the staff dining table. Numerous alive and dead bugs were across the approximately eight-foot-wide windowsill ledge. V26, Housekeeper then opened the refrigerator door. The refrigerator rubber seal was broken in three places. Living cockroaches were actively crawling into the refrigerator via the broken seal area. Living and dead cockroaches were present on each of the three shelves and in clear plastic drawers, the shelves and in the drawers of the refrigerator. There were too many to count. V26 confirmed the cockroach infested staff lounge shares a wall with the kitchen and steam table food service line. On 11/21/25 at 2:05 pm V27, Dietary Assistant, toured the steam table food service line that shares a wall with the staff lounge. There were six drawers under the food service counter and undercabinet below the drawers. There were a large amount of living and dead cockroaches throughout the cabinets and drawers. The drawers contained serving spoons, spatula and metal scoops. There were too many cockroaches to count. Adjacent to the cabinet and drawers was a steam table and cold food bar. Two living cockroaches were crawling out of a crack at the top of the cabinet and onto the salad bar serving counter. V27 stated Bugs are definitely the problem, and have been a problem for a long, long time. I don't know why this happens when they say they have sprayed. We supposedly have a company that comes out. Monthly I believe, but it's not working, and the facility knows it. It needs to be addressed aggressively. It wouldn't surprise me if a resident complained of a bug in their food, but I have not heard anyone do that. It's only a matter of time, before it happens. On 11/23/25 at 7:40 am V2, Director of Nursing (DON) walked down to the steam table food service line. Breakfast trays were actively being plated with utensils later confirmed to be from the cockroach infested drawers on the steam table service line. V2, DON confirmed there were serving utensils, spatula, scoops and large spoons in drawers that contained living and dead bugs. V2 DON directed dietary staff to stop plating resident's food until clean utensil were obtained from the dishwasher. V2 further explained to the dietary staff that from here forward these six drawers and lower cabinets are not to be used until the cockroach infestation is resolved. V29, Dietary Aid confirmed that she had removed the utensils being used to serve residents food this morning, from the same drawers on the steam table food service line that had the cockroaches in them. V2, then stated I know we have a contracted pest control company that has sprayed for bugs several times. Obviously, it is not working. V2 then entered the staff lounge next to the serving line. V2 confirmed that the staff lounge shared a wall of the kitchen and a wall with the steam table food service line. V2 also confirmed there are living and dead bugs in the refrigerator due to a broken seal, under and on the radiator baseboard, under the dining table and on the windowsill. The facility (Private Company) General Pest Control Maintenance invoices dated 9/26/25 and 10/20/25 both document: High Severity level of German Cockroaches were found in the kitchen of the facility during the inspection. Both invoices further document: Recommendation: Kitchen Employees sanitation practices need improvement. Please ensure employees are following proper sanitation guidelines mandated by your facility. On 11/26/25 at 10:05 am V1, Administrator reviewed the above private pest control company invoices and acknowledged the invoices recommendation for better kitchen sanitation practice to combat the German cockroach infestation. The facility undated Dietary Services Policy documents the following: 35. All food storage, preparation and distribution areas and equipment shall be constructed and situated so that it can be easily cleansed and maintained in a sanitary manner. 36. Food preparation areas shall be kept clean and free of possible sources of infection by strict adherence to Dietary Service Policy and</p>		

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NAME OF PROVIDER OR SUPPLIER Fair Havens Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ staff that are licensed, certified, or registered in accordance with state laws.</p> <p>Based on interview and record review the facility failed to ensure a qualified licensed nurse administered medication to an undetermined number of residents. This failure has the potential to affect all 95 residents in the facility. Findings include: V39's Health Care Worker Background Check date 01/26/16 documents V39 is eligible to work as Certified Nursing Assistant (CNA). The facility undated Certified Nursing Assistant job description does not include administration of resident medication. The employee corrective action report dated 11/21/25 and signed by V2, Director of Nursing and V39, Certified Nursing Assistant documents Employee will not pass (administer) medications without having the proper license to do so. On 11/21/25 at 12:20 pm V39, Certified Nursing Assistant (CNA) stated I am an LPN (Licensed Practical Nurse) Student, but I don't have my Licensed yet. I am not done with school. I am not supposed to give the residents medication. I did help a nurse pass medication one day. She was busy, so I helped. I think it was sometime in July or August. (V9, Licensed Practical Nurse) asked me to hand out some medications to residents (V39, could not recall which residents) who were lined up in the hallway waiting for their medications. I only helped. There were probably four or five residents I gave them too. I can't remember who they (residents) were. That was a long time ago. I did not put the medication in the cups. I don't know who got what. (V9, LPN) would tell me who to give the cup of pills to, and tell me if the resident needed them in applesauce. If (V9, LPN) said the resident got them whole, I gave them whole. (V9, LPN) put the meds (medication) in the cup, not me. (V9, LPN) knows I am not done with school. I am not sure, looking back, why she had me give them (medications). I was just trying to help. On 11/21/25 at 12:30 pm V2, Director of Nursing (DON) stated Absolutely, it is not alright for a CNA to administer medications, at any time. The nurses all know it is standard of practice that the licensed nurses are responsible for the administration of medication. The nurse that pulls (takes) the medication out of the stock, and puts them in the cup, are totally responsible to administer the medication. The nurses know the steps include making sure the medication is accurate and are given to the right resident. They (Nurses) know what the medications are given for, a CNA would not. I was not aware (V9, Licensed Practical Nurse) had (V39, CNA) helping her give the medications. This will be addressed right away. The facility undated Medication/Treatment Administration Policy documents the Director of Nursing, Licensed Nursing Personnel and Qualified Medication Aides are responsible for the administration of medication. The facility CMS Matrix 802 form dated 11/20/25 documents 95 residents reside in the facility.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility repeatedly failed to document administration of medication on the Medication Administration Record for one (R4) of three reviewed for medication administration. Findings Include: The Undated MEDICATION/TREATMENT ADMINISTRATION RECORD POLICY documents It is the policy of this facility that each medication/treatment administered will be promptly documented in the medication record after administration. The policy documents the purpose is to validate residents are receiving drugs and biologicals as ordered by the physician. 9. Documents Nursing personnel administering medication/treatments will abide by all Medical Records Policies. R4's care plan documents R4 admitted to the facility on [DATE] with diagnosis of Fracture of Right Femur, Chronic Ulcer of Other Part of Right Lower Leg, Chronic Ulcer of Other Part of Left Lower Leg, And Abnormalities of Gait and Mobility. On 12/2/25 at 10:30am record review documents on 10/23/2025 at 2:15pm a physician's order was obtained for Hydromorphone HCl Oral Tablet 4 MG. Directions are to give 1 tablet by mouth every six hours as needed for pain. On 12/2/25 at 10:45am record review of the Controlled Drug Receipt/Record /Disposition form documents R4 was administered Hydromorphone on the following dates 11/1/25 at 09:00am and 2:00pm, 11/2/25 at 09:00am, 2:00pm and 2:30pm, 11/3/25 at 06:30am, 11:00am, 7:00pm, and 11:15pm, 11/4/25 at 1:00pm and 7:00pm, 11/5/25 03:00am, 11:00am, and 7:00pm, 11/6/25 at 0500 am and 09:00am, 11/7/25 at 7:00pm, 11/8/25 at 02:00am, 7:00pm, and 11:50pm, 11/9/25 at 04:20am and 7:00pm, 11/10/25 at 03:00am and 11:00pm, 11/11/25 at 03:30am, 1:50pm, and 9:00pm, 11/12/25 at 03:00am, 3:00pm and 8:00pm, 11/13/25 at 05:15am, 11:15am, and 7:00pm, 11/14/25 at 8:00pm, 11/15/25 at 08:00am, 12:00pm, and 09:00pm, 11/16/25 08:00am, 11/17/25 at 08:00am and 1:00pm, 11/19/25 at 8:00pm, 11/20/25 at 10:00am and 1:15pm, 11/21/25 at 12:00pm, and 10:00pm, 11/22/25 at 05:00am, and 8:00pm, 11/23/25 at 04:00am and 11/25/25 at 08:00pm. On 11/26/25 at 11:00am V8 Registered Nurse stated if V8 signed the Controlled Drug Receipt/Record /Disposition form then the medication was administered. V8 stated that if any nurse signs out the Controlled Drug receipt/Record /Disposition form then the medication is to be documented on the Medication Administration Record for the resident. On 12/2/25 at 11:00am V2 and V43 confirm the physicians order stated for the Hydromorphone to be given every six (6) hours as needed for pain. V2 and V43 reviewed and confirmed the Controlled Drug receipt/Record /Disposition form documents R4 was administered the medication on the various days at above date and times. V2 and V43 confirm R4 Medication Administration Record for November 2025 does not document the administration of the medication at the dates and times above.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain a resident room free of odors from urine-soaked clothing. This failure affects one of three resident (R7) review for laundry services on the sample list of 35. Finding include: R7's Minimum Data Set (MDS) dated [DATE] documents R7's Brief Interview of Mental status score of nine out of a possible 15, indicating, severe cognitive impairment. The same MDS documents R7 requires Substantial/maximal assistance - Helper does 'MORE THAN HALF' the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. (for) Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment. On 11/23/25 at 6:13 am V34, Housekeeping/Laundry Worker was in the soiled utility room V34 pushed a large cart of soiled laundry out of the room. V34 stated Laundry is picked up on the units at least every shift and taken to the laundry room. We try to get the laundry back to the residents the same day. That is not always possible. That's our goal. On 11/23/25 at 6:20 am V30 Certified Nursing Assistant (CNA) stated (R7) takes herself to the bathroom frequently. She is supposed to ask for help, but she has some Alzheimer's. She gets confused at times and other times she's clear as a bell. She does remove her own clothes. We try to keep them picked up off the floor and put them in plastic bags. I was here when (V14, Family Member) came in and found all the clothes on the floor. We filled two garbage bags, big garbage bags with urine-soaked clothes. We took them immediately down to the laundry. I'm not sure why that was not being done. It obviously had been stacked up like that for days. I see she has more soiled clothes on her floor today (observed by surveyor). All of us CNAs know we are supposed to be picking up her dirty clothes, and helping her go to the bathroom, so she doesn't take off her clothes and leave them in the floor. We are supposed to be making sure they (soiled laundry) go to the laundry room at least by the end of our shift. I can understand why (V14 R7's Family Member) was so upset. It was a huge amount of laundry. I'm not sure how it accumulated, to that degree. I can confirm it was there and it did stink. On 11/26/25 at 1:00 pm V14, R7's Family Member stated There were several large garbage bags of urine-soaked clothes that had accumulated on the floor of (R7's) room. Some, I am sure were wet from the chair (R7) sets in. I have asked staff repeatedly to put a pad down, instead of (R7) using her clothes in the recliner to set on. (R7) pees through her clothes and has saturated the clothes she is setting on, and the seat of the recliner. The undated policy Housekeeping Services Policy documents the following: Policy: It is the policy of this facility to maintain clean, order (sic odor) free, comfortable and orderly environment in all healthcare and public areas, which meet the sanitation needs and resident's right for safe, clean, comfortable home-like environment. Policy Specifications: To ensure that the facility, equipment, furnishings and resident rooms are maintained in a sanitary manner: to provide a comfortable environment, and to prevent the development and transmission of infection.</p>		

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<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>Based on observation, interview, and record review the facility failed to maintain an effective pest control program by failing to prevent cockroaches in the kitchen and serving/steam table area. This failure has the potential to affect all 95 residents in the facility. Findings Include: On 11/21/25 at 2:06pm Policy and Procedure: Pest Control Policy and Procedure dated 2/3/2022 documents this facility shall maintain an effective pest control program. On 11/19/25 at 9:40 AM the floor areas throughout the resident meal serving/steamtable area adjacent to the kitchen was observed with remnants of pest/cockroaches on glue boards and remnants/carcasses of dead cockroaches were also noted on the back counter/back splash area. On 11/29/25 at 1:45pm R4 stated on 11/13/25 at an unknown time R4 felt something on the left leg, when R4 pulled the covers back R4 saw a cockroach crawling on R4's left leg. R4 further stated R4 witnessed a cockroach crawl out from under the heating/AC unit in the room. R4 stated R4 was unable to kill cockroach and the cockroach crawled back under the heating/ac unit and was out of sight. On 11/20/25 at 12:27 PM V16, Maintenance Director, stated the facility is aware there are cockroaches in the kitchen, adjacent meal serving/steamtable area and resident rooms. V16 stated pest control companies have sprayed the kitchen, adjacent meal serving/steamtable area and resident rooms. V16 stated in-between pest company spraying V16 also sprays for cockroaches. V16 stated V16 does not keep track of the dates, times or chemical used to spray for the cockroaches. On 11/20/25 at 12:37 PM V16, Maintenance Director, provided invoices from pest control company dated 8/29/25, 9/26/25 and 10/20/25. All invoices document there are cockroaches in the kitchen and public areas. On 11/21/25 V29, Dietary Aide, stated there are cockroaches in the kitchen, adjacent meal serving/steamtable area and resident rooms. V29 proceeded to open drawers and cabinets in the steamtable/serving area and showed dead and alive cockroaches to surveyor. On 11/23/25 at 10:25 am two surveyors observed a cockroach that was running up the wall behind the television in the conference room that is adjacent to the kitchen, and adjacent resident meal serving/steamtable area. The facility CMS Matrix 802 form dated 11/20/25 documents 95 residents reside in the facility.</p>		