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	12/10/2025

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 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide hygienic catheter care, monitor urinary catheter output, and timely treat symptoms of urinary tract infection for three of four residents (R2, R5, R49) reviewed for urinary catheters/urinary tract infections (UTIs) in the sample list of 49. These failures resulted in R49 developing urinary retention, UTI, urosepsis, acute kidney injury, and hydronephrosis that required hospitalization and urinary stent placement. Findings include:1.) On 12/07/2025 at 8:13 AM, R49 was observed lying in bed with a urinary catheter drainage bag attached to the bed frame. A sign near R49's doorway indicated that R49 was on Enhanced Barrier Precautions (EBP), requiring gown and gloves for high-contact care activities, including catheter care and transfers. A container with personal protective equipment (PPE) was present on R49's door.At 1:04 PM, R49 stated he had had the catheter for a long time and that it was last changed approximately one month earlier while hospitalized for a UTI. R49 stated that staff do not empty the catheter as often as they should and that some staff provide better catheter care and cleaning than others. V32, R49's spouse, stated that staff should have identified changes in R49's urine. V32 further stated that she received a phone call the night R49 was sent to the hospital with red-tinged urine and that R49 required placement of urinary stents.On 12/08/2025 at 10:55 AM, V5 and V7, Certified Nursing Assistants (CNAs), entered R49's room with a full mechanical lift while R49 was seated in his wheelchair. V5 and V7 did not don gowns upon entering the room. At 11:04 AM, R49 was in bed, and V5, V6, and V7 were present in the room without gowns. All three staff members washed their hands, applied gloves, and assisted with catheter care without wearing gowns. V7 cleansed and dried R49's inner thighs and penis, making contact with the urinary catheter multiple times. V7 cleansed the catheter tubing near the insertion site but did not clean the length of the tubing as required.R49's Minimum Data Set (MDS), dated [DATE], documents that R49 scored in the higher range for moderate cognitive impairment and has a urinary catheter. R49's active care plan includes a problem dated 10/24/2024 for urinary catheter use, with interventions to change the catheter as ordered and to monitor, record, and report signs and symptoms of UTI, including no urine output.R49's physician progress note dated 05/24/2025, recorded by V35, Urologist, documents that R49 was admitted to the hospital with an indwelling urinary catheter, severe UTI, and sepsis. The note documents that R49's catheter was changed and that R49 requires monthly catheter changes, which could be performed at the long-term care facility or in V35's office. This plan was discussed with R49 and his family. A urology progress note dated 10/03/2025 documents continuation of the indwelling catheter with monthly changes. R49's December 2025 Medication Administration Record (MAR) documents an order to change the urinary catheter as needed as of 07/08/2025. R49's June 2025 MAR documents an order to change the catheter every 30 days. There is no documentation in R49's medical record that the catheter was changed after 06/23/2025 until 11/16/2025, when R49 was hospitalized . There is also no documentation that urinary catheter output was routinely measured or monitored during this period prior to 12/04/2025.A nursing note dated 11/16/2025 at 12:47 PM documents that R49 had no urine output, low blood pressure and pulse, difficulty speaking and swallowing, altered mental status, lethargy, and labored breathing. R49's temperature was 99.1 F, pulse 29 beats per minute, respirations 18 per minute, and blood pressure 102/57. The physician was notified on 11/16/2025 at 6:51 AM.R49's Hospital History and Physical dated 11/16/2025 documents admission for urosepsis, septic shock, catheter-associated UTI, acute kidney injury, bilateral hydronephrosis, and bilateral renal cysts. R49's creatinine was 3.9 on arrival, compared to a baseline of approximately 0.8. R49 presented with lethargy, pulse rates in the 130s, and systolic blood pressure in the 80s despite fluid administration. R49 had urinary retention upon arrival; the catheter was changed with a return of nearly 900 milliliters of purulent urine. R49 has a history of multidrug-resistant bacterial infections. A physician progress note dated 11/21/2025 documents urine culture results of greater than 100,000 colony-forming units (CFU)/mL of mixed bacteria, continued IV antibiotics, and placement of bilateral urinary stents on 11/17/2025.On 12/08/2025 at 1:47 PM, V5 and V6, CNAs, were questioned regarding EBP. V6 stated PPE is worn whenever entering the room. V5 stated that for catheter care, gown and gloves are worn and that staff identify residents on precautions by posted signage and PPE supplies. V5 correctly described catheter cleaning as a downward motion approximately four inches from the insertion site. V5 and V6 confirmed that gowns were not worn during R49's transfer and catheter care. At 1:59 PM, V7 confirmed she did not clean the four inches of catheter tubing and did not wear a gown during catheter care.On 12/09/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement appropriate infection control practices during medication administration, failed to wear appropriate (Personal Protective Equipment (PPE)) when caring for residents on EBP or Contact Precautions, failed to post proper signage for residents requiring EBP or Contact Precautions, failed to ensure PPE supplies were readily available outside resident rooms for ten (R2, R7, R8, R18, R21, R30, R49, R56, R64, R89) out of ten residents reviewed for Infection Prevention and Control on a sample list of 49. These failures have the potential to compromise resident safety and increase the risk of transmission of infectious agents. Findings include: 1.) R56's Electronic Medical Record (EMR) contained culture results dated 11/20/25 documenting that R56's urine was positive for Escherichia coli (Extended Spectrum Beta-Lactamase [ESBL]) and Providencia stuartii (P. stuartii). R56's Physician Order Sheet, dated November 2025, documented an order for R56 to remain on Contact Isolation for urinary ESBL E. coli and P. stuartii every shift until 12/14/25, or until cleared by the physician. On 12/07/2025 at 8:57 AM, Contact Isolation signage was posted on the door of the shared room for R56 and R64. No personal protective equipment (PPE) container was observed in or near the room. R56 stated staff did not wear gowns or gloves when entering the room or providing care. On 12/07/2025 at 8:57 AM, V27, Certified Nursing Assistant (CNA), entered the room shared by R56 and R64 without donning a gown or gloves. V27 stated she was unsure whether R56 was on Contact Isolation. R56 stated she was on isolation while on antibiotics but was no longer taking them. V27 stated staff may have forgotten to remove the sign. On 12/09/2025 at 10:04 AM, the Contact Isolation sign remained posted on the door to R56 and R64's room. No PPE was observed outside or near the room. R56 stated she had recently completed antibiotics for a urinary tract infection (UTI), her symptoms had resolved, and she believed she was no longer on isolation. On 12/10/25 at 11:05 AM, V9, Registered Nurse (RN) and Infection Preventionist (IP), stated staff should have continued using Contact Isolation for R56 because the facility could not confirm clearance of the infection following completion of antibiotics. V9 confirmed she entered the order to continue Contact Isolation through 12/14/25 until a physician order was received to discontinue isolation. V9 stated R56 remained in the shared room with R64 due to lack of available private rooms. V9 stated staff should have worn PPE when entering R56's room. 2.) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/07/2025 at 8:25 AM, R89 was observed lying in bed with a nasal oxygen cannula in place and a urinary catheter hanging on the left side of the bed. R89 stated no one had changed the catheter tubing and that it had been lying down. R89's Minimum Data Set (MDS), dated [DATE], documented that R89 has an indwelling catheter and is cognitively intact. No physician order for Enhanced Barrier Precautions (EBP) was present until 12/10/25. On 12/07/2025 at 9:05 AM, R21 was observed lying in bed and stated she was admitted with a pelvic fracture and had a urinary catheter. No Enhanced Barrier Precautions signage or PPE was present. R21's MDS, dated [DATE], documented she is cognitively intact and has an indwelling catheter. R21's physician orders and care plan did not include Enhanced Barrier Precautions. On 12/07/2025 at 9:58 AM, R18 was observed lying in bed with a gauze dressing on the left foot. Documentation identified the wound as a blister. No Enhanced Barrier Precautions signage or PPE (gowns or gloves) was present on the door. Follow-up observations on 12/08/2025 at 1:18 PM and 12/09/2025 at 9:49 AM continued to show no Enhanced Barrier Precautions signage or PPE for R18. On 12/07/2025 at 11:00 AM, R30's room door displayed a Contact Precautions sign. Physician orders dated 11/07/2025 documented Methicillin-Resistant Staphylococcus aureus (MRSA) in R30's left leg wound. R30's MDS documented he is cognitively intact. R30 stated staff did not wear gowns or gloves when providing care. On 12/08/25 at 11:46 AM, V12, CNA, obtained vital signs for residents in Rooms 321-1 and 321-2 using the same vital signs machine without disinfecting it between residents. V12 exited the room wearing her gown, pushed the vital signs machine to the nurses' station, went to the tray cart, then entered the linen room and removed the gown. V12 stated she should not have worn the gown outside the resident room. V12 stated she was only educated that Enhanced Barrier Precautions apply to residents with Foley catheters or infections. On 12/08/25 at 1:05 PM, V1, Director of Nursing, confirmed that Enhanced Barrier Precautions require use of gowns and gloves and that vital signs equipment must be disinfected with bleach wipes between residents. V1 stated the facility was completing facility-wide education on Enhanced Barrier Precautions. V1 stated R30, R18, R21, and R89 should all have been on Enhanced Barrier Precautions and staff should have worn gowns and gloves during care. On 12/09/2025 at 9:51 AM, V10, Wound Nurse, stated R18 should have been on Enhanced Barrier Precautions due to the left foot wound. 3.) On 12/07/2025 at 8:13 AM, R49 was observed lying in bed with a urinary catheter secured to the bed frame. A sign near the doorway indicated R49 was on Enhanced Barrier Precautions, requiring gown and gloves for high-contact care activities, including catheter care and transfers. A PPE container was present outside the room. At 1:04 PM, R49 stated he had the catheter for a long time and that it was last changed approximately one month prior during hospitalization for a UTI. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/08/25 at 10:55 AM, V5 and V7, CNAs, entered R49's room with a full mechanical lift while R49 was seated in a wheelchair. Neither CNA donned a gown upon entry. At 11:04 AM, R49 was in bed, and V5, V6, and V7 provided catheter care without wearing gowns. All three performed hand hygiene, applied gloves, and completed catheter care without gowns. On 12/08/25 at 1:47 PM, V5 and V6 were interviewed regarding Enhanced Barrier Precautions. V6 stated PPE is worn whenever entering a resident's room. V5 stated gown and gloves are worn for catheter care and that staff identify residents on precautions by signage and PPE carts. V5 demonstrated catheter care technique. V5 and V6 confirmed gowns were not worn during R49's transfer or catheter care. At 1:59 PM, V7 confirmed she did not clean approximately four inches of catheter tubing and did not wear a gown during catheter care. On 12/10/2025 at 9:35 AM, V9 stated the purpose of Enhanced Barrier Precautions is to protect residents from transmission of microorganisms. V9 stated staff are expected to wear gowns and gloves when Enhanced Barrier Precautions are in place. 4.) On 12/07/2025 at 10:19 AM, no signage was observed outside R7's room indicating Enhanced Barrier Precautions. A PPE cart was present outside the room. R7 was observed lying in bed with a gastrostomy tube. At 10:25 AM, V3, CNA, stated R7 was on Enhanced Barrier Precautions due to the gastrostomy tube and confirmed signage should have been posted. 5.) On 12/07/2025 at 10:10 AM, no signage indicating isolation or Enhanced Barrier Precautions was observed outside R2's room. V42, RN, stated R2 had a Foley catheter and a left leg wound and should have been on Enhanced Barrier Precautions. V42 confirmed signage should have been posted. On 12/09/25 at 1:25 PM, V38 and V39, CNAs, transferred R2 from the toilet to her wheelchair in the 200-unit shower room and then to bed using a full mechanical lift. V39 handled R2's urinary drainage bag. Neither CNA wore a gown during care, as confirmed by V39. A sign outside R2's room indicating Enhanced Barrier Precautions was reviewed with V39, who stated she believed gowns were only required during wound or catheter care. R2's urine culture and sensitivity dated 12/08/25 documented 50,000–99,999 CFU/mL Escherichia coli (ESBL) and 25,000–50,000 CFU/mL Vancomycin-Resistant Enterococcus faecalis (VRE). From 12/07/25 through 12/10/25, R2 shared a room with R8. On 12/10/25 at 11:05 AM, V9 stated R2 should have been placed on Contact Precautions rather than Enhanced Barrier Precautions due to the presence of ESBL and VRE in urine. 6.) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/08/2025 at 10:48 AM, V4, LPN, prepared 2 units of Novolog (100 units/mL) and 10 units of Lantus (100 units/mL) using separate syringes. V4 did not disinfect the vial stoppers prior to needle insertion and administered the insulin to R49's abdomen without performing hand hygiene or applying gloves. At 10:55 AM, V4 confirmed she did not disinfect the vials and did not perform hand hygiene or wear gloves prior to administration. On 12/08/2025 between 11:28 AM and 11:45 AM, V4 prepared and administered R2's oral medications. V4 placed R2's pills directly into her hands before placing them into a medication cup. V4 drew up 2 units of lispro insulin (100 units/mL), placed the uncapped syringe in her pocket, entered R2's room, and administered the insulin using the same syringe. On 12/09/25 at 3:06 PM, V2, Director of Nursing, stated insulin vials must be disinfected with alcohol prior to each use, hand hygiene must be performed before and after medication administration, gloves must be worn when administering insulin, and needles must not be placed in pockets. The facility's Insulin Administration Policy (April 2007) requires handwashing, disinfecting vial tops with alcohol, withdrawing the prescribed dose, administering insulin, and disposing of needles in designated sharps containers. The facility's Handwashing/Hand Hygiene Policy (November 2013) identifies hand hygiene as the primary method to prevent infection transmission and requires hand hygiene before handling medications, before and after resident contact, and prior to nonsurgical invasive procedures. The facility's Infection Prevention and Control Manual – Transmission-Based Precautions (2020) states Enhanced Barrier Precautions are used to prevent transmission of multidrug-resistant organisms, require gowns and gloves during high-contact care for residents with wounds or indwelling devices, require posted signage and PPE availability, and include cohorting residents with the same infectious organism.