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	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Havens Senior Living	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)
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. Based on observation, interview and record review, the facility failed to protect the resident's right to be free from physical abuse by another resident for one (R1) of eight residents reviewed for abuse in the sample of list of eight. This failure resulted in R1 obtaining fingernail marks and bleeding to the right forearm when R2 scratched R1 during a physical altercation. Findings Include:The Facility Abuse Prevention and Reporting policy effective 11/2017, 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 physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. The policy documents as part of the resident's life history on the admission assessment, comprehensive care plan, and MDS (Minimum Data Set) 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.The Nursing Progress Note dated12/24/25 at 7:18PM by V22 Licensed Practical Nurse documents Writer heard a commotion in the resident's room when I went inside, I observed both roommates physically touching each other. (R2) was in her wheelchair with back facing (R1's) bed and (R1) had her back facing the door she was stating 'she's got ahold of me, she's on my side of the room bothering my stuff,' (R2) yelled back 'and so what are you going to do about it.' I removed the object they were both holding (a Hanger) and gently pulled (R2's) hands off (R1's) arm. I pulled (R1) out into the hallway, then pulled (R2) into and down the hallway where they were a good distance apart, but I could keep an eye on both. While assessing both I observed (R1's) forearm bloody. Once area was cleaned, I noticed what appeared to be nail marks and a couple of superficial scratches. Area cleansed, TOA (Triple Antibiotic Ointment) applied and covered. Resident is now in room alone; she says arm is sore but wants to wait for bedtime tramadol. On 1/26/2026 at 11:07AM, R2 was lying in bed, on her right side with R2's bed against the wall. R2 stated I don't remember R2 started calling for the Certified Nursing Assistant to get R2 out of bed.On 1/26/2026 at 11:15AM, R103 who stated she is R2's roommate, stated that R2 hits and screams at the staff when the staff try to help R2 with any activities of daily living. On 1/26/2026 at 12:05PM, V22 Licensed Practical Nurse stated that R1 has had behaviors of aggressiveness. V22 also stated R1 received fingernail scratches from R2 due to R2 was on R1's side of the room going through R1's personal belongings and R2 wanted the remote which led to an altercation and R2 becoming aggressive with R1. On 2/4/2026 at 11:00AM, V2 (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Director of Nursing) stated there was no skin assessment or care plan update/revision for R1 completed after the incident on 12/24/25 between R1 and R2. V2 stated R1 did receive fingernail scratches on R1's Right Forearm by R2. V2 also stated the facility has no behavioral services and if a resident needs behavioral services, the facility sends the resident out to a behavioral center. V2 stated R2 has not been evaluated by a behavioral center, and no abuse or behavioral assessments were completed after the resident-to-resident interaction.On 2/4/2026 at 12:38PM, V1 Administrator confirmed there were fingernail scratches on R1's right forearm and R2 was removed from R1's room and that R1 didn't want R2 as a roommate.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review the facility failed to ensure transportation staff were trained according to manufacturer's instructions to safely secure a wheelchair in the transportation van and failed to check a security strap when a resident reported movement of the wheelchair. These failures resulted in R3 sliding forward in the wheelchair when the transportation van was moving down a hill away from the facility which then resulted in the wheelchair flipping forward and R3 sliding out of the wheelchair onto the floor causing R3's left leg to become entangled in the foot pedal and underneath R3's body. After landing on the floor from the wheelchair, R3 was screaming in severe pain and sustained a 17-centimeter laceration to the left lower leg which required eight sutures and fractures of the left tibia and fibula (lower leg) which required hospital admission. These failures affect three of three residents (R3, R8, R12) reviewed for accidents in the sample list of 16.The Immediate Jeopardy began on 12/10/25 when R3 slid from the wheelchair onto the van floor while being transported to a physician appointment. V1 Administrator was notified of the Immediate Jeopardy on 2/2/26 at 2:20pm. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 2/3/26, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service and physical training.Findings Include:R3's Care Plan dated 4/29/2024 documents an admission date of 04/29/2024. The Care Plan documents R3's diagnoses as Acute on Chronic Diastolic (Congestive) Heart Failure, Morbid (Severe) Obesity Due To Excess Calories, Hypertension, Localized Edema, Depression, Anxiety Disorder, Heart Disease, and Chronic Kidney Disease. The Care Plan further documents R3 has Weakness, Bilateral Lower Edema, and Impaired Mobility and R3 uses a wheelchair for mobility and requires one-two staff members assistance to complete Activities of Daily Living.On 1/26/26 at 09:00 AM V1, Administrator provided an Investigation Report for R3's 12/10/25 fall. The Investigation Report documents R3 is alert and oriented, that R3 needs staff assistance with activities of daily living and transfers, that R3 is unable to ambulate, and R3's mode of locomotion is manual wheelchair and R3 needs assistance with propelling.The same report documents this Summary of events/situation:- On 12/10/25 At 12:30pm it was reported to V2, Director of Nursing (DON) that R3 had fallen out of her wheelchair while being transported. V2 entered bus and noted R3 with buttocks on wheelchair while upper body and head were resting on arm rest of vehicle, left leg beneath R3, right leg on foot pedal. Nurse (V11 Licensed Practical Nurse (LPN)) from unit, DON, and Transportation aid removed the seat belt from across R3 and removed all other attachments from the wheelchair and assisted R3 onto the floor. Nurse (V11) completed head toe assessment and noted R3 had multiple lacerations to the left lower extremity. R3 stated, When driver went over bump in the road, I slid forward in my wheelchair. Range of motion noted in all extremities except when the left leg was moved R3 complained of pain. Physician made aware and gave orders to send to ER (Emergency Room) for evaluation and treatment. POA (Power of Attorney) made aware of fall and of orders to send to ER for evaluation and treatment. Nurse cleansed left lower extremity, applied ABD (abdominal pad), and covered with kerlix. R3 returned to the facility with eight sutures to left upper anterior laceration and left tibia and fibula fracture. Root cause: R3 slid forward in wheelchair. The same investigation dated 12/10/25 at 12:30pm documents V13's (Van Driver), witness statement dated 12/10/25 as stating I (V13) was pulling away from the building when I heard Res (R3) screaming. I (V13) looked in the rearview mirror and saw Res (R3) leaning forward in w/c (wheelchair), bracing self on the seat next to her. I drove back around to get help; she (R3) couldn't hold herself up. Her (R3) leg went back underneath her, and blood was everywhere.The same investigation dated 12/10/25 at 12:30pm documents V2's witness statement (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	dated 12/12/25 as Writer (V2) was called out to come out to van by transportation aide (V13) stating res (R3) had fallen. Writer entered bus and noted res (R3) leaning forward resting on arm rest of vehicle. Buttocks at the edge of chair with left leg bent. Right leg extended with large amount of blood noted. Res was released from wheelchair and assisted onto bus floor. Nurse (V11 LPN) completed assessment. Ambulance called.R3's Emergency Department (ED) physician notes dated 12/10/25 at 1:56pm document on 12/10/25 at 1:45pm Chief Complaint: R3 arrived to the ED (Emergency Department) for a fall 20 minutes ago out of a wheelchair in a transport van. Complaint of bilateral lower extremity pain. Lacerations to the left and right lower extremity, currently mild bleeding noted. Associated diagnosis: Fall involving wheelchair causing injury; Displaced Oblique fracture of shaft of left tibia. V14, Orthopedic Surgeon's note dated 12/31/25 documents: This patient (R3) fell out of her wheelchair while in a transport van on 12/10/2025. She was taken to local hospital with complaints of bilateral lower leg pain. She did sustain several lacerations to the lower extremities as well. They obtained x-rays and a CT (Computed Tomography) scan of the left lower extremity. A left proximal tibia fracture and left fibular head fracture was noted. The Note documents V14 was consulted on 12/11/25 and R3 has been toe touch weightbearing to the left lower extremity in a knee immobilizer but is essentially wheelchair bound and remains in the immobilizer. This note documents an impression of the CT Scan of R3's Left Lower Extremity performed at the local hospital, as fracture of the proximal tibia metadiaphysis (upper region of the tibia), fracture of the fibular head, fracture of the distal fibula with the extension to the level of the ankle syndesmosis (joint and supporting ligaments that connect the tibia and fibula) and anterior inferior tibiofibular avulsion fracture from the anterior syndesmotic tubercle (bony prominence on the front outer aspect of the distal shin bone).On 01/28/2026 at 09:45am V13, Van Driver stated (on 12/10/25) V13 took R3 to the van via a wheelchair, applied wheelchair restraints, lap belt, closed the doors and got into the drivers' seat and began driving down the hill in front of the facility. V13 then stated V13 heard R3 yell out. V13 stated she looked into the mirror, saw R3's wheelchair tipped forward, and R3 leaning forward, V13 then put the van in park, and looked at R3, and decided V13 needed help and drove the van around the parking lot as fast as she could back up the hill on the other side to the main entrance and ran inside to get staff to help. V13 stated V2 and V11 came outside to help R3. On 01/28/2026 at 10:00am V11, License Practical Nurse, stated on 12/10/25 V13 came into the building in a panic requesting help, V2 Director of Nurses and V11 went to the van. V11 stated R3 was sitting on the floor in front of the tipped wheelchair with blood under R3. V11 stated R3 slid forward and was sitting on the floor of the van on R3's buttocks. V11 then demonstrated by leaning the chair forward and stated the wheelchair was tipped forward like this and R3 was leaning onto the chair/seatbelt. V11 stated they (V2 and V11) had a difficult time unlatching the seat belt and wheelchair due to the tension of R3's body weight and wheelchair positioning. V11 stated the scene resembled a car accident. V11 stated after getting R3 free of seatbelts and moving the wheelchair, R3 was then re-assessed and noted to have a large laceration to the top of the left shin. V11 stated V2 applied pressure while V11 retrieved dressing supplies. V11 stated EMS (Emergency Medical Services) arrived and took over care of R3 as V11 finished the dressings. V11 stated R3 was alert and oriented and complained of severe pain in the left leg.On 01/29/26 at 09:19am V11, License Practical Nurse (LPN), stated the restraint straps were still attached to the wheelchair, but extended out taught and V13 was struggling to free the straps while V11 and V2 were trying to help free R3 from the wheelchair/shoulder strap.On 01/28/2026 at 09:52am V2, Director of Nursing (DON) stated (on 12/10/25) V13 came inside asking for help, V2 and V11 went to the van. V2 stated the wheelchair was tipped forward, R3 was on the floor with R3's left leg under her and (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	straight out to chair and attaches to appropriate anchor point on the wheelchair frame.Does not allow straps to twist.Allows straps to retract and manually tightens them by twisting the ratchet knob.Secures FRONT of wheelchair inside wheelchair van:Confirms floor anchor positions for straps are on outward sides from front corners.Pulls straps straight out to chair and attaches to appropriate anchor point on the wheelchair frame.Does not allow straps to twist.Allows straps to retract and manually tightens them by twisting the ratchet knob.The above checklist is check marked as training completed and verified by V5, Maintenance Director/Trainer for V13's training checklists dated 10/10/25 and 12/11/25.On 2/2/26 at 10:00am review of the (Company Name) Use and Care Manual-- Vehicle Anchorages & Accessories For 4-Point Wheelchair Securement Systems dated 2020: Documents on page four the following: Tie-Down Hooks must be attached to a solid wheelchair frame (no spokes, wheels or movable components) at an approximate 45-degree angle with floor. The manual further documents: The (Company Name) 4-Point Wheelchair Securement Systems should not be operated by anyone who does not have full comprehension of how the system works or if the system is not working properly. This (Company Name) 4-Point Wheelchair Securement System and its components MUST be regularly inspected, cleaned and maintained-reference the Maintenance and Care section in this manual. Page 21 documents: The following items should be inspected and serviced by an experienced and trained technician during the scheduled maintenance of the (Company Name) 4-Point Wheelchair Securement System. Always keep belts clean and off the floor by using a storage device such as a (Company Name) wall pouch. We recommend one storage device per wheelchair location. All systems and components MUST be regularly inspected, tightened, cleaned, and maintained.On 01/26/26 at 09:17am V15, R3's Family stated he was advised R3's wheelchair tipped over in the van, broke R3's leg, and R3 had to go to the hospital. V15 stated that on 12/31/26 R3 had a follow up appointment with the orthopedic surgeon (V14) and that R3 required surgery and R3 had new wounds on R3's left leg, left heel and right heel. V15 stated R3's left leg wound became heavily infected and R3 passed away from the infection.The facility presented an abatement plan to remove the immediacy on 2/2/26. The survey team reviewed the abatement plan and was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility for revisions. The facility presented a revised abatement plan on 2/3/26, and the survey team accepted the abatement plan on 2/3/26.The Immediate Jeopardy that began on 12/10/25 was removed on 2/3/26 when the facility took the following actions to remove the Immediacy.On 2/3/26 Surveyor was able to confirm onsite that the facility took the following measures to remove the immediacy:On 2/3/26 V2, Director of Nursing, conducted in-service education about the proper securing of resident wheelchairs in the transportation van, including the newly developed facility policy, for the six approved transportation drivers and the maintenance director.On 2/3/26 V2, Director of Nursing, utilized a video training about the securement straps and seat belts in the transportation van for each of the six approved transportation drivers and the maintenance director.On 2/3/26 V2, Director of Nursing, conducted return demonstrations for each of the six approved transportation drivers and the maintenance director.On 2/3/26 V2, Director of Nursing, developed a new facility policy for securement of wheelchairs in the transportation van.On 2/3/26 V2, Director of Nursing, reviewed the job description for the transportation drivers.On 2/3/26 V2, Director of Nursing, developed a list of approved transportation drivers.On 2/3/26 V2, Director of Nursing, conducted an Ad-Hoc Quality Assurance Meeting to discuss the Immediate Jeopardy citation, needed training, proficiency checklist, list of approved drivers, review of transportation aide job description, development and corporate approval of facility policy, and abatement plan.On 2/3/26 V2, Director of Nursing, began conducting audits for three residents utilizing the facility van to be transported to appointments, R102, R103, and R104.On 2/3/26 V2, Director of (continued on next page)

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