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	05/29/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to place the call light within reach of one (R2) of five (R1, R2, R3, R5 and R6) residents reviewed for alternative communication methods in the sample of six residents.Findings include:The Facility Policy and Procedure for Call Light System dated 1/1/2025 documents that it is the policy of the facility to provide a means of communication to meet the needs of each resident. Staff will follow established procedures to respond to the residents' requests and needs. This policy further documents to assure the call light is within easy reach of the resident.R2's Care Plan dated 5/13/2026 documents admission date of 07/15/2025. This Care plan documents a diagnosis of history of falling, anxiety disorder, cognitive impairment and dementia.R2's Minimum Data Set (MDS) dated [DATE] documents R2 has moderate cognitive impairment.R2's Care Plan dated 7/15/2025 documents R2 is at risk for falls related to deconditioning, gait/balance problem, unaware of safety needs, vision/hearing problems. This Care plan documents a goal of R2 will be free of falls through the next review. This care plan further documents an intervention to ensure R2's call light is within reach and encourage R2 to use it for assistance as needed. R2 needs prompt response to all requests for assistance.Facility's Incident log dated 5/28/2026 documents R2 had multiple incidents of falls on different dates; 4/25/2026, 5/8/2026, 5/12/2026, and 5/17/2026.On 5/28/2026 at 9:37am, R2 was sitting in R2's wheelchair in the room with the call light on the floor next to R2's bed. R2 was located in the middle of the room and was approximately seven feet away from the call light.On 5/28/2026 at 10:00 am, R2 was in R2's wheelchair in the room with the call light on the floor (same area as 9:37 am) and not within R2's reach.On 5/28/2026 at 11:47 am, R2 was in R2's wheelchair in the room with call light remaining on the floor next to the bed (same area as 9:37 am) and out of reach. R2 stated R2 does not know where the call light is.On 5/28/2026 at 12:15 pm, R2 was in R2's wheelchair in the middle of the room, call light remains on the floor next to the bed (same area as 9:37 am) and out of reach.On 5/28/2026 at 12:15 pm, V4 Certified Nurse Assistant (CNA) came into R2's room to talk to R2. This surveyor asked V4 where the call light should be placed. V4 stated call lights should be where residents can see it and closer where residents do not need to move a lot to reach it. V4 confirmed R2's call light was on the floor and V4 stated R2's call light should not be on the floor. V4 did not pick up or move the call light at this time. On 5/28/2026 at 12:18 pm, V5 Registered Nurse (RN) stated call light should be next to the residents where the residents can reach it. V5 confirmed R2's call light was on the floor and V5 stated R2's call light should not be on the floor because R2 cannot reach it. V5 stated V5 will move the call light next to R2 at this time.On 5/29/2026 at 7:40 am, R2 was lying in bed at this time. Call light was noted to be clipped to the privacy curtain approximately four feet from the floor and approximately five feet away from R2.On 5/29/2026 at 7:45 am, V13 Certified Nurse Assistant (CNA) confirmed call light was clipped to the privacy curtain and stated it should be next to R2 and not clipped to the curtain.On 5/29/2026 at 12:09 pm, V2 Director of Nursing stated V2 expects the call lights to be within resident's reach.

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 - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the use of an indwelling (foley) catheter anchoring device for three (R1, R4, R5) of four (R1, R3, R4 and R5) residents reviewed for catheters in the sample of six residents.Findings include:R1's Care Plan dated 4/8/2026 documents an admission date of 03/06/2026. The Care Plan documents a diagnosis of Obstructive and Reflux Uropathy and Retention of Urine.R1's Care Plan dated 01/13/2026 documents R1 requires use of indwelling foley catheter due to diagnosis of Retention and Obstruction.R1's Minimum Data Set (MDS) dated [DATE] documents R1 has an indwelling catheter.R1's Minimum Data Set (MDS) dated [DATE] documents R1 has moderate cognitive impairment.R1's Order Review Report dated 5/29/2026 documents a physician order dated 3/6/2026 for foley catheter care every shift.On 5/28/2026 at 11:01 am, an observation conducted of V9 Restorative Aide and V10 Certified Nurse Assistant (CNA) providing catheter care for R1. During this observation, R1's indwelling catheter was not secured to R1's leg and there was no catheter anchoring device observed in place.On 5/28/2026 at 11:32 am, V10 CNA confirmed R1 did not have the catheter anchoring device in place and V10 stated R1 should have a catheter anchoring device in place at all times to keep the indwelling catheter in place and prevent it from getting pulled out. V10 stated R1 did not have the anchor device when V10 got R1 up this morning.On 5/28/2026 at 11:35 am, V9 Restorative Aide confirmed R1 did not have the catheter anchoring device at this time and stated R1 should have the anchor to keep the foley catheter in place.On 5/28/2026 at 11:44 am, V8 Licensed Practical Nurse stated all residents that have indwelling catheter should have anchor in place to keep the indwelling catheter from getting pulled out of the bladder.R4's Care Plan dated 5/13/2026 documents an admission date of 04/13/2026. The Care Plan documents a diagnosis of Obstructive and Reflux Uropathy and Hydronephrosis.R4's Care Plan dated 5/01/2026 documents R4 requires use of indwelling foley catheter related to diagnosis of Bladder Obstruction and Hydronephrosis. This care plan documents an intervention to monitor for decreased output. Pain, cloudy, foul-smelling urine, abdominal distention, and fever. Report abnormalities to Medical Director.R4's Situation, Background, Assessment, Recommendation (SBAR) note dated 5/20/2026 R1 was sent to the hospital due to symptoms of being diaphoretic, hypotension, elevated pulse, distended abdomen with pain on palpation, emesis and poor output.R4's hospital electronic medical records dated 5/20/2026 documents an impression of decreased urine output, and hematuria with labs and urinalysis consistent with urinary tract infection and possible sepsis, complicated by acute kidney injury and hydronephrosis in the setting of foley malfunction/malposition.On 5/29/2026 at 9:59 am, V17 (R4's) family member stated V17 was at the emergency room (ER) with R4 on 5/20/2026 and confirmed the indwelling catheter was changed by the emergency room (ER) nurse upon R4's arrival at the ER and confirmed there was no catheter anchoring device in place on R4's indwelling catheter at that time. R5's Care Plan dated 4/8/2026 documents an admission date of 01/17/2026. This Care Plan documents a diagnosis of Obstructive and Reflux Uropathy.R5's Care Plan dated 9/24/2025 documents R5 has an indwelling catheter due to diagnosis of obstruction.R5's Minimum Data Set (MDS) dated [DATE] documents R5 is cognitively intact.R5's Order Review Report dated 5/29/2026 documents a physician order dated 3/25/2026 for foley catheter care every shift.On 5/28/2026 at 1:31 pm, an observation was conducted of V6 Certified Nursing Assistant (CNA) and V7 Restorative Aide providing foley catheter care for R5. During this observation, there was no catheter anchoring device observed in placed on R5's catheter.On 5/28/2026 at 1:42 pm, V6 CNA confirmed there was no catheter anchoring device on R5 when V6 got R5 up this morning. V6 stated R5 should have an anchoring device to keep the foley catheter in place.On 5/28/2026 at 1:45 pm, V7 Restorative Aide confirmed that R5 did not have the anchoring device at this time. V7 stated nurses are the ones who applies the anchoring device and CNAs should (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be reporting to the nurse if there is no anchoring device in place on a resident.On 5/28/2026 at 1:59 pm, V8 Licensed Practical Nurse (LPN) stated nurses applies the catheter anchoring devices and confirmed all residents that have foley catheters should have the anchoring device in place to keep the foley catheter from getting pulled out of the bladder. V8 stated no one told V8 that R5 did not have a catheter anchoring device.On 5/29/2026 at 12:09 pm, V2 Director of Nursing stated V2 expects all residents that have indwelling catheter to have a catheter anchoring device in place at all times to keep the catheter from getting pulled out of the bladder.Facility's Catheter Care, Urinary policy dated September 2005 documents ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site.