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

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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 0557 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, Interview and Record Review the facility failed to protect the dignity and psychosocial wellbeing for two residents (R26, R69) reviewed for dignity out of a sample list of 49. This failure resulted in psychosocial harm for R26, R69 with feelings of disrespect.Findings Include: 1.) The Minimum Data Set, dated [DATE] documents that Resident R26 is severely cognitively impaired, requires maximum assistance with activities of daily living, and has a diagnosis of dementia. On 12/07/2025 at 8:30 AM, R26 was observed lying in bed on the left side, with the right side of the head positioned partially on a pillow and partially against the wall. The wall next to the bed, which was flush with the west wall, had noticeable dried brown hand wipes on the white surface. On 12/07/2025 at 8:51 AM, V2 (Director of Nursing) observed R26 and stated that the substance on the wall was feces and that the resident's head was lying in the feces. On 12/08/2025 at 2:31 PM, V11 (R26's Power of Attorney) stated that R26 was in the facility for rehabilitation. V11 stated that no one had contacted them regarding R26's head lying in feces and further stated, My mom wouldn't have appreciated her head lying in poop. 2.) The Minimum Data Set, dated [DATE] documents that Resident R69 is cognitively intact and requires maximum assistance with activities of daily living. On 12/07/2025 at 8:27 AM, R69 stated that when needing to use the restroom, the call light system is activated; however, at times it has taken over an hour for staff to respond. R69 stated this delay resulted in urinary incontinence and made the resident feel disrespected. On 12/07/2025 at 11:40 AM, V15, Licensed Practical Nurse, stated that all call lights should be answered as quickly as possible and that a response time of over an hour is not acceptable. V15 further stated that R69 is alert and would know when restroom assistance is needed. The facility policy, revised April 2007, documents that the facility will make every effort to assist each resident in exercising their rights to ensure that residents are always treated with respect, kindness, and dignity.

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to properly transfer a resident (R2) for one of two residents reviewed for accidents in the sample list of 49. This failure resulted in bruising and pain to R2's right leg. Findings include:The facility's Safe Lifting and Movements of Residents policy, dated August 2008, documents that resident transfer needs will be assessed on an ongoing basis and that transfer status will be documented in the care plan.On 12/07/2025 at 10:30 AM, R2 stated that the previous night staff struck the back of her right leg against the bed frame while using a sit-to-stand lift. R2 stated that management was aware and had looked at her leg that morning. R2 grimaced when moving her right leg and stated that the incident caused pain to her right leg.On 12/09/2025 at 1:10 PM, V38 and V39, Certified Nursing Assistants (CNAs), used a sit-to-stand lift to transfer R2 onto the toilet in the 200-unit shower room. R2 held on with both hands, bore weight with a bent posture, and the chest strap remained loose. R2 did not fully stand, and her knees remained bent. R2 had lymphedema (swelling) in both legs. V39 stated that R2 uses a full mechanical lift for transfers in and out of bed and a sit-to-stand lift for toilet transfers, which was approved by therapy.At 1:28 PM, V38 and V39 transferred R2 from the toilet back to her wheelchair using the sit-to-stand lift. R2 was observed to have a baseball-sized blue/purple bruise on the back of her right calf/knee. R2 stated, See what they did to me. They banged my leg on the bed. It hurts. V39 asked R2 if she had reported this to the nurse, and R2 stated that nurse management was aware. R2 exhibited visible facial grimacing, moaning, and complaints of pain during the transfers.V38 and V39 transported R2 to her room and transferred her into bed using a full mechanical lift. V39 stated that staff do not tighten the chest strap on the sit-to-stand lift because R2 refuses and does not like it, and that R2 usually stands better than that. A sign posted on R2's wall near the bed instructed staff to use a full mechanical lift for bed transfers and a sit-to-stand lift for toilet transfers.At 1:44 PM, R2 stated that some staff use the full mechanical lift and some use the sit-to-stand lift to transfer her into bed. R2 stated that she did not have right leg pain prior to the incident that caused the bruise.R2's Minimum Data Set, dated [DATE] documents that R2 is cognitively intact and dependent on staff for chair, bed, and toilet transfers. R2's care plan documents a diagnosis of lymphedema and was revised on 11/18/2025 to reflect transfer status as a mechanical sit-to-stand lift for toileting in the shower room and a full mechanical lift to and from bed. This information is also reflected in CNA task lists and charting.R2's nursing note dated 12/07/2025 at 6:35 AM documents bruising and hardening to the back of the right leg near the knee area, with complaints of slight pain. Nursing notes and the December 2025 Medication Administration Record document that Tramadol 50 mg was administered on 12/07/2025 at 8:30 AM for complaints of right leg pain rated 5 out of 10, with follow-up pain rated at 4.On 12/09/2025 at 2:40 PM, V25, CNA, stated that she worked on R2's hallway on Saturday night (12/06/2025) and that a sit-to-stand lift was used to transfer R2 into bed; however, V25 stated she was not the individual who rammed R2's leg into the bed frame. V25 stated that V26 was the other CNA assisting with R2's transfers that night and that V26 operated the lift. V25 stated that she did not realize anything had occurred until R2 asked V25 and V26 to look at her leg after the transfer because R2 felt something on the back of her leg. V25 stated she had recently started working on that hallway and had asked how R2 transferred; she was told R2 used a sit-to-stand lift. V25 stated it was not until Sunday that she learned R2 was supposed to use a full mechanical lift, after V2, Director of Nursing, spoke to her regarding R2's bruising.On 12/09/2025 at 2:49 PM, V2 stated that R2's bruise occurred during a transfer when R2 was positioned too close to the bed. V10, Licensed Practical Nurse/Wound Nurse, stated that she investigated R2's bruising and interviewed R2 and the CNAs. V10 stated that R2 reported the CNAs used a sit-to-stand lift to transfer her into bed and pushed too hard on the lift, causing R2's leg to strike the metal bed frame. V10 interviewed V25 and V26 and confirmed (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	that V26 operated the lift with assistance from V25. V10 stated that both CNAs were educated on proper transfer techniques, instructed to use caution during transfers, and issued verbal warnings for improper transfer, as R2 requires a full mechanical lift for bed transfers.Employee Disciplinary Reports dated 12/07/2025 document that V25 and V26 received verbal warnings for improper transfer, specifically using a sit-to-stand lift instead of a full mechanical lift, resulting in the resident sustaining a bruise to the leg after contact with the metal bed frame.

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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. **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 (continued on next page)

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	145422	A. Building B. Wing	12/10/2025

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F 0690 Level of Harm - Actual harm Residents Affected - Few	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 at 10:33 AM, V9, Infection Preventionist (IP), stated that catheter changes are completed per physician orders and documented in nursing notes or on the MAR or Treatment Record. On 12/10/2025 at 9:35 AM, V9 stated that the purpose of EBP is to protect residents from staff-transmitted germs and that staff are expected to wear gown and gloves when EBP is in place, particularly for residents with urinary catheters.On 12/09/2025 at 10:36 AM, V10, Licensed Practical Nurse/Wound Nurse, stated that per the 10/03/2025 urology note, R49's catheter was to be changed monthly. V31, MDS Coordinator, stated that she rounded with V33, R49's primary physician, who changed the catheter order to as needed without consulting the urology office. V10 stated that urine output monitoring would be documented on CNA task sheets. At 12:22 PM, V10 stated R49 was seen by urology in April, May, October, and November 2025. V10 further stated that R49's catheter was last changed on 06/23/2025 and that there was no documentation of catheter changes until 11/16/2025, no follow-up with urology regarding the order change, and no documentation of urine output monitoring until 12/04/2025, when an audit was completed by V2, Director of Nursing.On 12/09/2025 at 12:02 PM, V34, Urology Nurse for V35, stated that R49 was seen as a new patient in April 2025 and again in October 2025, and that V35 saw R49 during hospitalizations in May and November 2025. Provider notes indicated that R49's catheter was to be changed monthly, and no catheter changes were completed in the clinic. V34 stated that the facility should monitor for UTI signs such as changes in urine color or characteristics, cloudiness or blood, and complaints of flank pain. Standard nursing practice also includes measuring, recording, and monitoring urinary catheter output. Decreased output may indicate UTI. Failure to change a catheter can contribute to UTIs, and delayed identification or treatment of UTI can lead to sepsis. V34 stated that if these interventions had been performed, R49's hospitalization may have been prevented.On 12/10/2025 at 11:04 AM, V36, LPN, stated that she sent R49 to the hospital in November after the night nurse, V37, LPN, reported that during the 5:00 AM medication pass R49 was mumbling and experiencing swallowing difficulties. V36 stated she assessed R49's vital signs due to concern for possible sepsis given R49's history. R49 had minimal urine output, low pulse and blood pressure, and labored breathing.On 12/10/2025 at 11:41 AM, V37 stated that R49 appeared stable until approximately 5:30 AM, when a CNA reported that R49 was shaking and did not look well. Vital signs were checked and reported as normal, and the information was passed on in report. V37 stated she could not recall R49's urinary output that night, as nurses do not routinely document urine output.2.) On 12/09/2025 at 1:25 PM, V38 and V39, CNAs, transferred R2 from the toilet to her wheelchair in the 200-unit shower room. V38 pushed R2's wheelchair across the hall into R2's room, and R2's urinary catheter tubing was observed dragging on the floor, as confirmed by V39. A clip was attached to the tubing but was not used to keep the tubing off the floor. V39 removed R2's urinary collection bag from beneath the wheelchair and held it above the level of R2's bladder, causing urine to drain back toward the bladder, then placed the bag on R2's lap. Cloudy sediment was observed in R2's urine.V38 and V39 transferred R2 into bed using a full mechanical lift. The CNAs did not wear gowns during the transfers or while handling R2's urinary catheter, despite signage outside R2's room indicating Enhanced Barrier Precautions and the requirement to wear gowns for high-contact care. V39 acknowledged that the clip could be used to keep tubing off the floor and confirmed that the urinary collection bag had been raised above the bladder.R2's care plan dated 09/24/2025 documents (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	use of a urinary catheter. A urine culture and sensitivity dated 12/08/2025 documents 50,000-99,999 CFU/mL of Escherichia coli (ESBL) and 25,000-50,000 CFU/mL of vancomycin-resistant Enterococcus faecalis.3.) On 12/08/2025 at 9:54 AM, V40, R5's family member, stated concerns that R5 experiences frequent UTIs and that nursing staff do not always follow up in a timely manner when urinalysis is requested. V40 stated that nurses must request orders from the physician and that results sometimes take weeks.R5's MDS dated [DATE] documents severe cognitive impairment, total bowel and bladder incontinence, and dependence on staff for toileting hygiene.A nursing note dated 09/17/2025 documents that V40 reported R5 complained of burning with urination and foul-smelling urine. The physician was notified; however, there is no documentation that a urine sample was collected until 09/19/2025, nor are results documented from that sample. Nursing notes document that another urine sample was collected on 09/24/2025, with results received on 09/26/2025 (nine days after symptom onset). Orders were received for Keflex 500 mg twice daily for 10 days.R5's urine culture and sensitivity dated 09/26/2025 documents 50,000-99,999 CFU/mL of E. coli.On 12/09/2025 at 12:14 PM, V31, MDS Coordinator, stated that laboratory pickup occurs Monday through Friday and that on weekends staff must transport specimens to the local hospital. V9, Infection Preventionist, and V31 were asked to provide documentation that R5's 09/19/2025 urine sample was sent to the laboratory.On 12/09/2025 at 3:06 PM, V2, Director of Nursing, stated that no additional documentation was available regarding R5's urine samples or results.

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F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. F575 Required PostingsBased on observation, interview, and record review the facility failed to post the name, address, and telephone number of the state agency in an accessible location in the facility. This failure has the potential to affect all 95 residents currently residing in the facility. Findings:The facility's Long-Term Care Facility Application for Medicare and Medicaid, dated 12/07/2025, documents a census of 95 residents.On 12/09/2025 at 10:20 AM, during a Resident Council meeting, Resident R17 stated she had not seen any information posted in the facility related to the State Agency. Resident R34 then stated she denied seeing any information displayed in the facility regarding how to file a complaint with the State Agency. Residents R15, R37, R1, R52, R72, and R96, who were also present at the Resident Council meeting, agreed that they were not aware that State Agency information was posted in the facility.On 12/09/2025 at 11:18 AM, when asked whether the facility had a sign posted with State Agency information, V1, Administrator, directed this surveyor to the front entrance, past the alarmed entry doors, into the foyer, where contact information for the State Agency complaint procedure was displayed at an elevation above this surveyor's eye level while standing. The State Agency contact information was not clearly visible from inside the facility.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to serve meals at the posted times. This failure has the potential to affect all 95 residents in the facility. Findings Include:On 12/10/25 Record Review of DIET [NAME] SERVICES POLICY documents the dietary department shall maintain and keep current a policy and procedure manual inaccordance with applicable state and local requirements for food-service that ensures efficient operation and delivery of appropriate food service to residents. The policy further documents three (3) well-planned meals will be served at regularly scheduled hours. The facility's Long-Term Care Facility Application for Medicare and Medicaid dated 12/7/25 documents a census of 95 residents.On 12/10/25 at 09:30am V16, Certified Dietary Manager, confirmed the facility scheduled meal times are breakfast at 07:30am, lunch at 11:30am, and dinner at 5:00pm.On 12/07/25 breakfast was observed starting serving at 08:10am and lunch at 12:15pm.On 12/08/25 Breakfast was observed started serving at 08:17am. On 12/10/25 at 09:30am V16, Certified Dietary Manager, stated the breakfast meal was late being served today because no staff rolled silverware, and that needed done to serve breakfast. On 12/8/25 at 12:27pm R52 stated meals are served late all the time. On 12/7/25 V1, Admin, provided a binder that list the assigned meal times as breakfast at 07:30am, lunch at 11:30am, and dinner at 5:00pm

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. Based on observation, interview, and record review the facility failed to protect a resident's right to be free from misappropriation of medications by an employee. This failure affects five of five residents (R11, R49, R2, R14, R51) reviewed for misappropriation of medications in the sample list of 49. Findings include: The facility's Medication and Treatment Order Policy, dated February 2014, documents that drugs ordered for one resident shall not be used for another resident. The facility's Abuse Prevention Training Program, dated 11/22/2017, documents that misappropriation of resident property is the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. 1.) On 12/08/2025 at 10:48 AM, V4, Licensed Practical Nurse, stated that she had just checked R49's blood glucose, which was 49. V4 stated that R49 was out of insulin and that she would have to borrow medications, despite being taught in nursing school not to do so. V4 withdrew 2 units (u) of Novolog and 10 units of Lantus from R11's insulin vials and administered the insulin into R49's abdomen. At 10:55 AM, V4 stated that if a resident does not have their oral medications, the facility has a backup medication system; however, she was unsure whether insulin was included in that backup supply. R49's December 2025 Medication Administration Record (MAR) documents Lantus insulin 100 units/milliliter (u/mL), 10 units subcutaneously daily at 8:00 AM, and Novolog insulin 100 u/mL per blood glucose–based sliding scale, three times daily before meals. R11's December 2025 MAR documents that R11 receives Lantus insulin twice daily and Novolog insulin three times daily. On 12/07/2025 at 3:15 PM, V2, Director of Nursing, stated that it is never acceptable to borrow medications for another resident. V2 stated, I heard about that, referring to V4 using R11's insulin for R49. V2 further stated that the facility has a backup medication system that includes a supply of insulin, which V4 should have used. The Novolog Highlights of Prescribing Information, dated February 2023, document that insulin vials should not be shared between different patients, even if a different needle is used. 2.) On 12/08/2025 at 2:03 PM, medication storage was observed on Hall 200 behind the nursing station. On the counter were four pre-poured medications in pill cups stacked on top of each other. On 12/08/2025 at 2:10 PM, V4, Licensed Practical Nurse, stated that she is PRN only and was not aware of the facility's policies or procedures. V4 referred the surveyor to the Director of Nursing and discarded the pre-poured medications, which included R49's Pantoprazole 40 mg and Sucralfate 1 g; R2's Xarelto 15 mg; R51's Warfarin 2.5 mg; and R14's Apixaban 5 mg. V4 stated that the pre-poured medications on the counter were intended for the 5:00 PM medication pass. On 12/08/2025 at 2:20 PM, V1, Director of Nursing, came to the 200 unit and spoke with V4, asking whether she had pre-poured medications. V4 confirmed that she had pre-poured medications for (continued on next page)

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents R49, R2, R51, and R14. V2 stated that medications should not be pre-poured. V1 further stated that education would be completed with all nurses.

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

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to administer medications as ordered for two of six residents (R2, R49) reviewed for medication administration in the sample list of 49. This failure resulted in 8 errors out of 25 opportunities (a 32% medication error rate). Findings include:1.) On [DATE], from 11:28 AM to 11:45 AM, V4, Licensed Practical Nurse, prepared and administered the following oral medications to R2: Hydralazine Hydrochloride (cardiac medication) 50 milligrams (mg), Potassium Chloride 10 milliequivalents, Torsemide 20 mg, and Oxybutynin Chloride Extended Release 15 mg. V4 stated that R2's blood glucose was 150 and that R2 would receive 2 units (u) of insulin. R2's lispro insulin was not in its original box and was not labeled with a dispensed or opened date. The vial had a handwritten date of [DATE] next to the expiration/discard date. V4 administered 2 units of lispro insulin into R2's abdomen.V4 informed R2 that these were R2's morning medications. At 11:47 AM, V4 used an electronic blood pressure cuff to obtain R2's blood pressure readings of 162/121 in the left arm and 170/100 in the right arm. V4 administered Metoprolol Tartrate 50 mg at 12:00 PM. At 1:38 PM, V4 verified that R2's lispro insulin vial was labeled with an expired/discard date of [DATE]. V4 stated that medications are to be administered within one hour before or after the scheduled time.R2's [DATE] Medication Administration Audit Report (MAAR) documents the following for [DATE]: Hydralazine 50 mg is scheduled three times daily at 9:00 AM, 1:00 PM, and 9:00 PM; the morning dose was administered at 11:38 AM. Potassium Chloride scheduled at 9:00 AM was administered at 11:41 AM. Oxybutynin Chloride scheduled at 9:00 AM was administered at 11:39 AM. Torsemide scheduled at 9:00 AM was administered at 11:39 AM.R2's [DATE] blood pressure log documents that R2's blood pressure ranged from 130/72 to 170/100 between [DATE] and [DATE], with a reading of 170/100 recorded on [DATE] at 11:55 AM.On [DATE] at 12:41 PM, V41, Pharmacist, stated that Hydralazine should be spaced approximately 6-8 hours apart and Metoprolol Tartrate 10-12 hours apart. V41 stated that administering these medications too close to the next scheduled dose could increase medication effects, such as lowering heart rate and blood pressure, while late doses could result in elevated heart rate and blood pressure as the medication's effects diminish.2.) On [DATE] at 10:48 AM, V4, Licensed Practical Nurse, stated that she had just checked R49's blood glucose, which was 49. V4 stated that R49 was out of insulin and that she would have to borrow medications, despite being taught in nursing school not to do so. V4 withdrew 2 units of Novolog and 10 units of Lantus from R11's insulin vials and administered the insulin into R49's abdomen.At 10:55 AM, 11:20 AM, and 11:45 AM, R49 was observed in his room without a meal tray.At 10:55 AM, V4's medication administration screen showed several residents with red boxes, indicating overdue medications. V4 stated that she was behind on administering 8:00 AM medications, including R49's insulin. V4 stated that R49 ate breakfast around 7:00 AM and that she did not check R49's blood glucose before breakfast or administer R49's morning insulin. V4 stated that the unit was heavy, could benefit from two nurses, and that she is PRN (as needed) and does not have a routine, which contributes to delays. V4 stated that lunch trays are typically delivered to R49's unit around 12:00 PM.R49's [DATE] Medication Administration Audit Report documents that Lantus insulin 100 units/mL, 10 units subcutaneously daily at 8:00 AM, was administered at 10:52 AM, and Novolog insulin 100 units/mL per blood glucose-based sliding scale, scheduled for 8:00 AM, was administered at 10:48 AM on [DATE].The Novolog Highlights of Prescribing Information, dated February 2023, documents that this insulin is rapid acting and should be administered within 5-10 minutes of a meal. Adverse reactions include hypoglycemia (low blood glucose).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review the facility failed to ensure medications are administered timely resulting in significant medication errors for three of five residents (R2, R49, R56) reviewed for medication errors in the sample list of 49. Findings include:1.) On 12/08/2025, from 11:28 AM to 11:45 AM, V4, Licensed Practical Nurse (LPN), prepared and administered R2's oral medications, including Hydralazine Hydrochloride (cardiac medication) 50 milligrams (mg). V4 told R2 these were R2's morning medications. At 11:47 AM, V4 used an electronic blood pressure cuff to obtain R2's blood pressure, which was 162/121 in the left arm and 170/100 in the right arm. V4 administered Metoprolol Tartrate 50 mg at 12:00 PM. At 1:38 PM, V4 stated medications are to be given within one hour before or after the scheduled time.R2's December 2025 Medication Administration Audit Report (MAAR) documents the following: Hydralazine 50 mg is scheduled three times daily at 9:00 AM, 1:00 PM, and 9:00 PM. On 12/08/25, the morning dose was administered at 11:38 AM, and the afternoon dose was given at 2:08 PM. On 12/06/25, the morning dose was given at 11:10 AM, and the afternoon dose at 2:30 PM. Metoprolol Tartrate 50 mg is scheduled at 9:00 AM and 8:00 PM. On 12/08/25, the morning dose was given at 12:02 PM, and the evening dose was not administered until 4:17 AM on 12/09/25. On 12/07/25, the evening dose was not given until 12:35 AM on 12/08/25.2.) On 12/08/2025 at 10:48 AM, V4 stated she had just checked R49's blood glucose, which was 49. V4 stated R49 was out of insulin and that she would have to borrow the medication, despite being taught in nursing school not to do so. V4 withdrew 2 units (u) of Novolog and 10 units of Lantus from R11's insulin vials and administered them into R49's abdomen. At 10:55 AM, 11:20 AM, and 11:45 AM, R49 was in his room with no meal tray present.On 12/08/25 at 10:55 AM, V4's medication administration screen showed several residents (including R56 and R64) with red boxes, indicating medications were overdue. V4 stated she was behind on administering her 8:00 AM medications. V4 stated this hall is a heavy hall and could really use two nurses. V4 stated she is PRN (works as needed) and does not have a routine, which causes her to fall behind.R49's December 2025 MAAR documents: Isosorbide 10 mg is scheduled at 8:00 AM, 1:00 PM, and 8:00 PM. On 12/08/25, the morning dose was given at 10:43 AM, and the afternoon dose at 12:39 PM. Metoprolol Tartrate 25 mg is scheduled at 8:00 AM and 8:00 PM. On 12/08/25, the morning dose was given at 10:43 AM, and the evening dose at 8:52 PM. Hydralazine 25 mg is scheduled every eight hours at 6:00 AM, 2:00 PM, and 10:00 PM. On 12/08/25, the morning dose was given at 5:14 AM, and the evening dose was not given until 4:19 AM on 12/09/25. On 12/07/25, the evening dose was not given until 12:36 AM, less than five hours prior to the morning dose. On 12/05/25, the evening dose was given at 5:07 PM, and the morning dose on 12/06/25 was given at 6:21 AM.3.) On 12/08/2025 at 12:02 PM, R56 waved down the surveyor in the dining room and requested that the nurse be notified that she had not yet received her morning medications. V4 was notified.R56's December 2025 MAAR documents: Sacubitril-Valsartan 24-26 mg, give one-half tablet twice daily at 8:00 AM and 8:00 PM for congestive heart failure (CHF). On 12/08/25, the morning dose was given at 12:12 PM, and the evening dose at 4:18 AM. The evening dose on 12/07/25 was given at 12:36 AM. On 12/06/25, the morning dose was given at 9:30 AM, and the evening dose at 7:51 PM. Furosemide 60 mg is scheduled twice daily for CHF at 8:00 AM and 2:00 PM. On 12/08/25, this medication was given at 12:27 PM and 1:00 PM. On 12/06/25, it was given at 9:29 AM and 2:02 PM.On 12/08/25 at 3:15 PM, V2, Director of Nursing, stated she notified the physicians for R2, R49, and R54 of the late medication administrations. Medication lists were sent, and she was awaiting any new orders.On 12/09/25 at 3:20 PM, V4 stated the residents whose medications were given late received their next scheduled doses the previous day. V4 stated she did not hear back from the physicians with any new orders. V4 confirmed medication administration times are documented at the time of administration.On 12/10/25 at 11:04 AM, V36, LPN, stated the 200 unit (where R2, R49, and R54 reside) is a heavy hall with a heavy medication pass and is difficult to manage when issues arise. V36 stated a second nurse is needed to assist and could be shared (continued on next page)

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	145422	A. Building B. Wing	12/10/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	between units. V36 stated she often runs past the allowed medication administration window because over half of the residents on the unit are diabetic and many take multiple blood pressure medications.On 12/10/25 at 12:41 PM, V41, Pharmacist, stated Hydralazine should be spaced approximately 6-8 hours apart; Metoprolol Tartrate 10-12 hours apart; Isosorbide 8 hours apart; and Sacubitril-Valsartan 8-12 hours apart. V41 stated that administering these medications too close to the next scheduled dose could increase medication effects, such as lowering heart rate and blood pressure. V41 stated late doses could result in hypertension or tachycardia as medications gradually wear off. If administration is 25-50% past the scheduled time, consideration should be given to spacing the next dose later, stating, You don't want to double up on the medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure medications were not expired, discard discontinued medications, ensure multiuse vials were labeled with opened dates, maintain medications in their original packaging, and lock the medication cart when not in use. This failure affects five of six residents (R2, R17, R49, R51, R14) reviewed for medication storage in the sample list of 49. Findings include: The facility's Storage of Medications policy dated 10/27/14 documents that medication carts are to be locked when unattended to prevent unauthorized access to medications. Medications must be dispensed in containers that meet regulatory requirements, and nurses may not transfer medications from one container to another. Outdated and expired medications should be removed from inventory and properly disposed of. Medication storage conditions should be checked on a monthly basis. Certain multidose injection vials require a shorter expiration date than the manufacturer's expiration date to ensure medication potency. Opened vials must be labeled with a date-opened sticker and include both the date opened and the new expiration date. The nurse should check the expiration date prior to administration, and no expired medications should be administered to a resident. 1.) On 12/08/25 at 11:00 AM, V4, Licensed Practical Nurse (LPN), walked away from the 200-unit medication cart without locking it, leaving the cart unattended and out of V4's view. V4 confirmed the medication cart was left unlocked and stated it should be locked whenever it is unattended. On 12/08/2025, from 11:28 AM to 11:45 AM, during observation of R2's medication administration, R2's lispro insulin vial was not in its original box and was not labeled with a dispensed or opened date. The vial had a handwritten date of 11/23/25 next to the expiration/discard date label. V4 stated R2's blood sugar was 150 and that R2 would receive 2 units (u) of insulin. V4 administered the insulin into R2's abdomen. On 12/08/2025 at 1:38 PM, the 200-unit medication cart was reviewed with V4. There were two Tresiba pens for R17 with dispensed dates of 08/27/25 and 10/21/25, as confirmed by V4. V4 also confirmed that R2's Humalog/lispro insulin vial was not in its original box and did not contain an opened date, only a handwritten expiration/discard date of 11/23/25. R17's December 2025 Medication Administration Record (MAR) does not include an order for Tresiba. R2's December 2025 MAR documents that lispro insulin is ordered three times daily per sliding scale. On 12/09/25 at 3:06 PM, V2, Director of Nursing, confirmed that medications should be discarded once discontinued. The Lispro Instructions for Use, dated July 2023, document that all opened vials should be discarded after 28 days of use, even if insulin remains in the vial. 3.) On 12/08/2025 at 1:25 PM, the medication storage room and medication cart on the 300 Hall were observed with V8. V8 unlocked the medication refrigerator and removed house stock TB supplies, which V8 stated had been opened and had an expiration date of 06/05/25. Also observed in the refrigerator was expired insulin from a discharged resident with an expiration date of 06/26/25. Additionally, eight prefilled 10 mL normal saline flush syringes with an expiration date of 12/01/25 (continued on next page)

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	145422	A. Building B. Wing	12/10/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were present. An opened container of 2 Cal Vanilla Medication Pass was observed on top of the refrigerator with no expiration date. V8 stated this should have been discarded and that an expiration date should have been written on the opened container. The 300 Hall medication cart had approximately 50 loose pills scattered throughout the second drawer. On 12/08/2025 at 1:58 PM, V8 discarded the expired items and stated, I am not sure what is going on with expiration dates not being addressed, and there shouldn't be any loose pills. V8 stated that pharmacy usually reviews the drawers, but it is the nurse's responsibility to date any opened medication containers. On 12/08/2025 at 2:04 PM, the 200 Hall medication storage unit was reviewed with V4, LPN. During the review, V4 opened the first cabinet in the medication room, revealing 11 unidentified white pills marked GC216 and two pills marked GC101 placed in a pill cup. Also observed in the 200 East Hall medication storage area were pill cups containing pre-popped medications. These included Pantoprazole 40 mg and Sucralfate 1 g for R49; Xarelto 15 mg for R2; Warfarin 2.5 mg for R51; and Apixaban 5 mg for R14, all lying on the counter in the medication room. On 12/08/2025 at 2:10 PM, V4, LPN, stated she is PRN and was not aware of the facility's policies or procedures and referred questions to the Director of Nursing. V4 discarded the pre-popped medications for R49, R2, R51, and R14. On 12/08/2025 at 2:20 PM, V1, Director of Nursing, came to the 200 unit and spoke with V4, asking whether she had pre-popped medications. V4 confirmed that she had. V1 stated there should be no pre-popped medications. V1 further stated that issues related to loose pills, expiration dating, and medication disposal would be addressed and confirmed to V4 that the observed practices were not in accordance with facility policy. V1 discarded and removed the 11 pills marked GC216 and the two pills marked GC101 from the cabinet. V1 also stated that education would be completed with all nursing staff.

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	145422	A. Building B. Wing	12/10/2025

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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.) 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 (continued on next page)

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	145422	A. Building B. Wing	12/10/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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 (continued on next page)

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	145422	A. Building B. Wing	12/10/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.) 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, (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review the facility failed to reassess blood pressure with a manual cuff to verify accuracy and report an elevated blood pressure to the physician for one of six residents (R2) reviewed for medication administration in the sample list of 49. Findings include:The facility's Acute Changes in Condition Clinical Protocol, dated August 2008, documents that the nurse will monitor and report any changes in a resident's condition to the physician, including assessment of vital signs. The policy further documents that, prior to contacting the physician, the nurse should make pertinent observations and collect appropriate information to report, and that staff will document monitoring and responses to treatment.On 12/08/2025 at 11:47 AM, V4, Licensed Practical Nurse, used an electronic blood pressure cuff to obtain R2's blood pressure of 162/121 from the left arm and 170/100 from the right arm. V4 administered Metoprolol Tartrate 50 mg at 12:00 PM.R2's active care plan documents diagnoses of atrial fibrillation, hypertension, and heart failure and includes an intervention to monitor vital signs and report abnormalities to the physician. R2's December 2025 blood pressure log documents that R2's blood pressure ranged from 130/72 to 170/100 between 12/01/2025 and 12/08/2025, with a reading of 170/100 recorded on 12/08/2025 at 11:55 AM. There is no documentation in R2's medical record that blood pressure was reassessed after 11:47 AM until 5:12 PM on 12/08/2025. There is also no documentation that R2's elevated blood pressure was reported to the physician.On 12/08/2025 at 3:10 PM, V4 stated that she did not perform any follow-up on R2's blood pressure because it was considered a normal reading for R2 and the resident exhibited no signs of distress. V4 further stated that she did not reassess R2's blood pressure using a manual cuff.On 12/07/2025 at 3:15 PM, V2, Director of Nursing, stated that she would expect the nurse to have rechecked R2's blood pressure manually and, if it remained elevated, to have notified the physician.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide pressure relieving interventions for one of two residents (R49) reviewed for pressure ulcers in the sample list of 49. Findings include: The facility's Prevention of Pressure Ulcers policy, dated August 2008, documents that pressure ulcers form when residents remain in the same position for extended periods, causing increased pressure and decreased circulation to affected areas. The policy further documents that pressure ulcers can worsen due to continual pressure. Interventions include changing positions at least every two hours when in bed and every hour when in a chair.On 12/07/2025 at 8:13 AM, R49 was observed in bed asleep, lying on his back on an air mattress. On 12/07/2025 at 1:04 PM, R49 was again observed lying in bed on his back. R49 stated that he has sores on his buttocks that began while hospitalized and that his biggest pet peeve is that staff do not reposition him often enough or place him on his side.On 12/08/2025 at 10:48 AM, R49 was observed sitting in his wheelchair in his room. R49 has bilateral leg amputations. At 10:55 AM, V5 and V7, Certified Nursing Assistants (CNAs), transferred R49 to bed. At 11:04 AM, V5, V6, and V7, CNAs, provided urinary catheter care and cleansed R49's buttocks. R49 was noted to have large, patchy areas of moisture-associated skin damage (MASD)/superficial sores and one pea-sized open area on the coccyx.On 12/08/2025 at 11:20 AM, 11:45 AM, and 1:46 PM, R49 was observed lying in bed on his back. No pillows were positioned behind or beside R49's back or buttocks.R49's Minimum Data Set, dated [DATE] documents that R49 scored in the higher range for moderate cognitive impairment and is dependent on staff for bed mobility and transfers.R49's Wound Evaluation & Management Summary, dated 12/08/2025, documents a cluster of partial-thickness wounds related to MASD measuring 3.0 cm x 1.5 cm x 0.1 cm, as well as a left lower lateral MASD wound measuring 0.5 cm x 2.3 cm with no measurable depth. Recommended and planned interventions include offloading the wound, positioning side to side, and repositioning per facility protocol.R49's CNA task charting prompts turning and repositioning every two hours and the use of pillows for offloading. There is no documentation in R49's electronic medical record indicating that R49 refused repositioning or offloading.On 12/08/2025 at 11:47 AM, V5, CNA, stated that R49 was transferred to his wheelchair at approximately 7:40 AM and confirmed that R49 was not returned to bed until approximately 11:00 AM. At 1:47 PM, V5 confirmed that R49 had been lying on his back. V5 stated that she attempts to reposition R49 approximately every 1-2 hours and use pillows to position him on his sides; however, she stated that R49 has been refusing to lie on his sides due to complaints of pain and has been removing the pillows.On 12/09/2025 at 12:22 PM, V10, Wound Nurse, stated that R49 returned from the hospital with MASD and should be turned and repositioned every two hours, with limited time spent sitting. V10 stated that R49 is compliant and asks about ways to improve wound healing. V10 further stated that CNAs should notify the nurse of any refusals, notify the physician, document refusals, and implement behavior monitoring. On 12/09/2025 at 2:21 PM, V10 stated she was unable to find documentation of refusals of care for R49.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review the facility failed to administer gastrostomy tube feeding per physician's order and facility policy for one of one resident (R7) reviewed for gastrostomy tubes in the sample list of 49. Findings include: The facility's Gastric Tube Feeding via Syringe (Bolus) policy dated August 2008 documents verify the physician's order for product volume and review the resident's care plan. Attach the syringe without plunger to the tube and pour the prescribed amount of feeding into the syringe and allow to flow by gravity. Add the prescribed amount of water. Clamp tube and detach syringe. R7's Physician Order dated 10/17/25 documents to administer Jevity 1.5 Calorie 300 milliliter (ml) bolus feedings every six hours. On 12/8/25 at 1:12 PM V4 Licensed Practical Nurse stated R4 gets 600 ml of feeding. V4 used a syringe and plusher to push 600 milliliters of Jevity 1.5 cal into R7's gastrostomy tube. Between drawing up each syringe of feeding with one hand, V4 used her other hand to attempt to hold R7's gastrostomy tube, then laid R7's unclamped gastrostomy tube on R7's lap causing feeding to leak out. At 1:35 PM V4 confirmed R7's order is for 300 ml of feeding, not 600 ml. V4 confirmed R7's tubing was unclamped during administration causing feeding to leak out when placed on R7's abdomen. On 12/8/25 at 3:15 PM V2 Director of Nursing confirmed physician orders should be followed for volume of enteral feeding administration. V2 stated bolus feedings should be administered by gravity flow.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to offer and administer pneumococcal vaccinations for two (R21,R53) of five residents reviewed for immunizations on a sample list of 49. This deficient practice has the potential to place residents at an increased risk for developing pneumonia. Findings include:R21's Minimum Data Set (MDS) dated [DATE] documents that R21's thought process is moderately impaired.On 12/10/2025 at 10:32 AM, R21 stated she does not remember whether the facility asked her if she wanted the pneumonia vaccine at the time of admission. R21 stated she would like to receive the pneumonia vaccine if the facility offered it.On 12/10/2025 at 10:58 AM, V28 (R21's family member and Power of Attorney [POA]) stated she was present with R21 at the time of admission. V28 stated she recalled the facility offering the influenza and COVID-19 vaccines on admission, but not the pneumonia vaccine. V28 stated it would be beneficial for R21 to receive the pneumonia vaccine if possible.R21's undated Attachment H: Authorization and Release for Vaccinations document is marked as R21 refusing to sign the document.R53's Minimum Data Set (MDS) dated [DATE] documents that R53's thought process is intact.On 12/10/2025 at 10:36 AM, R53 stated she does not recall the facility offering her the pneumonia vaccine when she was admitted . R53 stated the facility offered her the influenza and COVID-19 vaccines this year but did not offer the pneumonia vaccine. R53 stated she would like to receive the pneumonia vaccine if it is available.On 12/10/25 at 11:30 AM, V29, Licensed Practical Nurse (LPN) and Admissions Coordinator, stated that upon admission she educates residents and families regarding the facility's vaccine program. V29 stated R21 declined the pneumonia vaccine on 11/07/25 and acknowledged that the Authorization and Release for Vaccinations form documenting R21's refusal should have been dated.On 12/10/25 at 12:36 PM, V2, Director of Nursing (DON), stated that simply asking residents on admission whether they want the pneumonia vaccine is not sufficient.The facility's Infection Prevention and Control Manual - Pneumococcal Vaccine Program, dated 06/2020, documents that it is facility policy to offer residents immunization against pneumococcal disease in accordance with Advisory Committee on Immunization Practices (ACIP) recommendations. Pneumococcal disease is described as a serious illness that can cause significant morbidity and mortality. The policy states the purpose is to reduce the incidence of pneumococcal disease and the associated morbidity and mortality.The policy further documents the nursing procedure as follows:Upon admission, staff are to follow the Facility Protocol for Pneumococcal Vaccines to determine resident eligibility.If a resident is admitted without physician orders, staff are to discuss the recommendation for shared decision-making regarding PCV-13 with the physician.The resident or the resident's representative has the right to refuse immunization.If immunization is refused, staff must document the education provided and the refusal in the medical record.