STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145469	A. Building B. Wing	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven of Paris	1011 North Main Street Paris, IL 61944

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to schedule a prompt appointment for physician ordered diagnostic Magnetic Resonance Imagining (MRI) of R2's right hip post-fall, and failed to obtain the results of the MRI in a timely manner. These failures resulted in R2's sustaining continued severe pain, and delay in surgical repair of a hip fracture. R2 is one of three residents reviewed for falls on the sample list of three. Findings include:R2's Current Diagnoses Sheet documents the following: Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety; Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side; Acute Neurologic Condition; Low Back Pain, Unspecified; and Dorsalgia, Unspecified.R2's Current Physician Order Sheet (POS) documents the following: Tylenol (analgesic) oral tablet, 325 mg - Give two tablets by mouth one time a day, related to Disorder of Muscle, Unspecified. Order Date: 05/20/2025. Tramadol HCL (narcotic analgesic) oral tablet, 50 mg - Give one tablet by mouth every 12 hours as needed for pain rated 7-10 (on pain scale with 10 being severe pain). Order Date: 04/16/2025. Aspirin oral chewable tablet, 81 mg - Give one tablet by mouth one time a day for prophylaxis. Order Date: 04/16/2025. Xarelto oral tablet, 20 mg - Give one tablet by mouth one time a day as a blood thinner. Order Date: 04/16/2025.R2's Minimum Data Set (MDS) dated [DATE] documents R2's Brief Interview of Mental Status score as 0 out of a possible 15, which indicates severe cognitive impairment.R2's Late Entry Nurse's Note dated 9/16/25 at 9:08 p.m. documents the following: This nurse (V20, Registered Nurse) was called to the North Hall shower room per CNA (V13, Certified Nursing Assistant), who stated that the resident (R2) had a witnessed fall during an assisted shower. CNA (V13) stated she was attempting to roll the resident out of the shower area in a wheelchair (w/c); the w/c got caught on a floor tile, and the resident (R2) fell out of the chair. Upon entry to the shower room, the resident was found lying on her right side with her head against the baseboard. Resident denied pain or discomfort. Head-to-toe assessment completed. Vital signs obtained. Resident assisted back to w/c. Resident agreeable to go to the ED (Emergency Department) for further workup due to hitting her head and being on a blood thinner. EMS (Emergency Medical Services) notified and en route. Resident at nurses' station with nurse until EMS arrived. Attempted to notify POA (V21, Power of Attorney); voicemail left. ADON (V3, LPN Nurse Supervisor), facility on-call manager (unidentified), and MD (unidentified physician) notified of incident.R2's Hospital emergency room Note dated 09/16/25 documents the following: Chief Complaint: Fall. Patient (R2) arrived via EMS from [Facility Name] Health Facility with complaint of a fall from standing. Healthcare facility states patient was in the shower, fell, and hit her head. EMS personnel state patient has a bump on the left side of her head that is chronic and a small bump on the right side from the fall. Patient did not lose consciousness. Patient is on blood thinners per [Facility Name] Health Facility. Facility staff state the patient is acting within her normal limits and at baseline (as noted on the above MDS, severe cognitive impairment), but they wanted her checked because she is on blood thinners. Patient denies neck and back pain and refused to have a C-collar placed by EMS. Patient has no other complaints at this time.R2's same Hospital emergency room Note documents that R2 underwent a Computed Tomography (CT) scan of the head and spine, which revealed no acute changes. (No diagnostic test or imaging was performed on R2's right hip.) R2 was returned to the facility. The hospital discharge summary instructed the facility to return R2 to the emergency room if new symptoms, regions of pain, or red-flag (serious or potentially life-threatening) symptoms developed.R2's Nurse's Note dated 9/17/2025 at 11:51 a.m. documents: Resident complained of right-sided hip and shoulder pain since the fall. Medical records from ER visit (9/16/25 post-fall) reviewed-no X-rays were obtained. Resident refusing to get out of bed due to pain. Spoke with resident's family member/POA (V21). Administrator (V1) approved transfer for evaluation. Received order from Nurse Practitioner (V22) to send to ER for complaints of increased pain in right shoulder and hip.R2's Second Transfer (Post-Fall) emergency room Note dated 09/17/25 documents:R2 was seen for Chief Complaint: Hip and Shoulder Pain. X-rays of the right shoulder and right hip were completed, showing no acute fracture or dislocation. The report also notes that the right hip X-ray did not have a true AP projection, indicating incorrect anteroposterior positioning, which can cause image distortion. The same note states: Consequently, if hip pain symptoms persist, consider non-contrasted CT scan of the right hip. No further diagnostics were performed until a family request on 09/29/25 (see below).R2's Narcotic Count Sheet documents that R2 received 26 Tramadol 50 mg tablets dispensed on 4/25/25. Only four doses were

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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** Failures at this level required more than one deficient practice statement: A. Based on observation, interview, and record review, the facility failed to provide a safe environment by leaving a normally secured bathroom door ajar, effectively failing to supervise R1, a resident with a diagnosis of dementia, to prevent a traumatic fall. This failure resulted in R1 falling and striking their head, sustaining a hematoma, a rib fracture with a partially collapsed lung, and two brain bleeds requiring emergency hospitalization and treatment at two separate hospitals. R1 was one of three residents reviewed for falls in a sample of three. B. Based on observation, interview and record review the facility failed to maintain a shower chair, in safe operable condition, which resulted in R2's fall with a hip fracture that required surgical repair. R2 is one of three residents reviewed for falls on the sample list of three. Findings include:A. R1's Resident Assessment (6/26/2025) documents R1 has moderately impaired cognition. The same record documents R1 uses a wheelchair for mobility, has wandering behavior, is dependent on staff for transfers and toileting, and requires substantial/maximal staff assistance to walk. R1's diagnosis list (10/14/2025) documents diagnoses including Dementia and Osteoarthritis (degenerative joint disease). R1's Fall Risk Assessment (6/14/2025) documents R1 is at high risk for falls. R1's Elopement Evaluation (9/5/2025) documents R1 is at high risk for elopement. R1's care plan (10/14/2025) documents R1 is at risk for falls and injuries due to medical factors, including Dementia, non-compliance, pain, poor safety awareness, and Osteoarthritis, with the intervention that staff should not leave R1 alone in R1's room when R1 is in a wheelchair. The same record documents R1 wanders in the facility. The facility Incident Investigation Summary (9/26/2025) documents R1 sustained a fall on 9/20/2025 in the facility dementia unit central bathroom, resulting in a head injury and was sent to the hospital emergency department. The facility Fall Investigation #1808 (9/20/2025) documents V4 (Licensed Practical Nurse) was walking down a facility hallway and noticed R1 trying to crawl out of a bathroom. The same record documents V4 observed a large hematoma (localized blood collection outside of blood vessels) on the right side of R1's forehead above the eyebrow, and R1 was sent to the hospital emergency department by ambulance. The hospital emergency department report (9/20/2025) documents R1 experienced an unwitnessed fall in a facility bathroom and was found by facility staff crawling on the ground with an abrasion/swelling to the right eyebrow and complaints of pain in the right rib cage. The same report documents R1 reported having a headache and was experiencing pain with respiration and with movement. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The hospital radiology report (9/20/2025) documents R1 sustained a large traumatic subdural hematoma (collection of blood between the brain and skull), subarachnoid hemorrhage (bleeding in the space between the brain and the membrane that covers it), fracture of right rib, pneumothorax (partially collapsed lung), and a hematoma adjacent to R1's right eyebrow. The same report documents R1 needed trauma surgery and was sent to a regional trauma center for a higher level of care. The Trauma Evaluation History and Physical (9/24/2025) documents R1 was admitted to the trauma center intensive care unit on 9/20/2025 and received an intravenous catheter, pain medication, and required surgical placement of a chest tube on 9/21/2025 to treat R1's worsening pneumothorax. The same record documents R1 remained hospitalized until 9/24/2025 before transferring back to the facility. On 10/15/2025 at 10:32 AM, V4 (Licensed Practical Nurse) reported working on the facility dementia unit on 9/20/2025 and noticing the door to the unit central bathroom was partially opened, and R1 was attempting to crawl out of the bathroom. V4 reported no other staff were present at the time, and V4 last observed R1 seated in R1's wheelchair in the dining room across the hall from the central bathroom waiting for supper. V4 denied staff continuously monitor the central bathroom and denied staff had provided R1 access to the bathroom to use independently. V4 reported R1 can make R1's needs known to staff and will tell staff when R1 needs to use the bathroom. V4 reported R1 has a history of frequently wandering in the dementia unit, room to room, looking for R1's brother or other people. On 10/15/2025 at 12:25 PM, the above central bathroom door on the dementia unit was fully closed and had a keypad lock mechanism present on the door handle, requiring staff to enter a code to open the door. V23 (Certified Nurse Aide) was nearby and attempted to open the door without success. The door slab appeared to be sticking, and V23 thrust V23's shoulder and feet forcefully against the door repeatedly, along with re-entering the unlock code several times before finally succeeding in opening the door after numerous attempts. On 10/15/2025 at 12:30 PM, V11 (Registered Nurse) reported the dementia unit central bathroom door required two staff to get open on 10/14/2025. V11 reported some residents will use the bathroom independently. On 10/15/2025 at 2:25 PM, the above door was slightly ajar with the latching mechanism not engaged. No facility staff were located in the vicinity of the central bathroom. On 10/15/2025 at 2:19 PM, V23 (Certified Nurse Aide) reported the central bathroom door began sticking shut and became difficult to open sometime over the summertime. V23 reported not being sure if any staff had submitted a maintenance work order to repair the malfunctioning door. V23 stated, I might need to put another (maintenance work order request) ticket in. V23 reported staff can submit maintenance requests through a software system accessible at the nurse's station adjacent to the dementia unit central bathroom, and V23 denied any issues with the facility maintenance department responding to requests in a timely manner. On 10/15/2025 at 2:28 PM, V24 (Certified Nurse Aide) reported not being certain facility staff had submitted a maintenance work order to repair the malfunctioning door. V24 stated, I've been meaning to (submit a maintenance work request for the door). V24 reported facility staff working on the dementia unit leave the door slightly ajar, unlatched, and unlocked to facilitate use of the central bathroom since the door sticks shut and is difficult to open. V24 denied the facility maintenance department has any delays in responding to work order requests submitted by nursing staff. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/16/2025 at 11:47 AM, the dementia unit central bathroom door was ajar, unlatched, and unlocked. On 10/16/2025 at 2:30 PM, V5 (Certified Nurse Aide) reported being on a break away from the dementia unit when R1 experienced an unwitnessed fall in the central bathroom on 9/20/2025. V5 reported R1 had been seated in R1's wheelchair in the dining room prior to V5 leaving the unit for a break, and V4 and V28 remained on the unit to take care of residents. V5 reported V28 (Certified Nurse Aide) was leaving the dementia unit for a break as V5 was returning to the unit, and V5 believed V28 was unaware R1 had accessed the unlocked bathroom independently and had experienced a traumatic fall to the floor and remained on the bathroom floor at the time V5 returned from a break. V5 reported V4 found R1 injured and attempting to crawl out of the bathroom after V5 had returned to the unit, and when V5 went to help with R1, R1's forehead was really bulged from R1's fall in the bathroom. V5 reported the dementia unit central bathroom door has always been hard to open, so the nursing staff leave the door cracked open, or else they have to type the unlock code into the keypad over and over again and punch the door to get it to open. V5 denied R1 had any history of attempting to unlock any doors with a keypad but would shake handles to doors sometimes. When the surveyor asked V5 if the bathroom door had remained shut and locked, could that have prevented R1 from accessing the bathroom independently and experiencing a fall, V5 replied, Yes. On 10/14/2025 at 3:20 PM, R1 was sleeping in bed with a large, hand-sized bruise remaining around R1's right eye, eyebrow, and forehead from R1's fall 24 days ago on 9/20/2025. The facility fall policy (9/2024) documents the intent of the policy is to ensure the facility provides an environment free from hazards over which the facility has control and provides appropriate supervision to each resident. B. R2's current Diagnoses Sheet documents the following: Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Acute Neurologic, Low Back Pain, and Unspecified Dorsalgia, Unspecified. R2's current Physician Order Sheet (POS) documents the following: Tylenol (analgesic) Oral Tablet, 325 mg, give 2 tablets by mouth, one time a day, related to Disorder of Muscle Unspecified – Order Date 05/20/2025; Tramadol HCL (narcotic analgesic) Oral Tablet, 50 milligrams (mg), give 1 tablet by mouth every 12 hours as needed for pain 7–10 (on pain scale with 10 being severe pain) – Order Date 04/16/2025; Aspirin, Oral Tablet Chewable, 81 mg, give 1 tablet by mouth one time a day for prophylaxis – Order Date 04/16/2025; and Xarelto Oral Tablet 20 mg, give 1 tablet by mouth one time a day for blood thinner – Order Date 04/16/2025. R2's Minimum Data Set (MDS) dated [DATE] documents R2's Brief Interview of Mental Status score as zero out of a possible 15, indicating severe cognitive impairment. The same MDS documents R2 uses a manual wheelchair and a walker for mobility. The same MDS documents R2 requires staff assistance with showering and that R2 has had no falls or pain during the look-back period of this assessment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R2's Late Entry Nurses Note dated 9/16/2025 at 9:08 PM documents the following: Note Text: This nurse (V20, Registered Nurse) was called to North Hall shower room per CNA (V13, Certified Nursing Assistant); states resident (R2) had a witnessed fall during assisted shower; CNA (V13) states (V13) was attempting to roll resident out of shower area in w/c (wheelchair); w/c got caught on floor tile, and resident (R2) fell out of chair; upon entry to shower room, resident was found lying on right side w/head against baseboard of floor; denies pain or discomfort; head-to-toe assessment complete; VS (vital sign measurements) obtained; resident assisted to w/c; resident agreeable to go to ED (hospital emergency department) for further work-up d/t (due to) hitting head and being on a blood thinner; EMS (Emergency Medical Services) notified and en route; resident @ (at) nurses' station w/nurse until EMS arrived; attempted to notify POA (V21, Power of Attorney), received voicemail; ADON (V3, LPN Nurse Supervisor), facility on-call manager (unidentified), and MD (unidentified physician) notified of incident. R2's Hospital emergency room note dated 9/16/2025 documents the following: Chief Complaint: Fall. Pt (Patient/R2) arrived via EMS from [NAME] Health Facility with c/o a fall from standing. Healthcare facility states pt was in the shower, fell, and hit her head. EMS personnel state pt has a bump on the left side of head that is there all the time, and there is a small bump on the right side of her head from where she hit it when she fell. Pt did not lose consciousness. Pt is on blood thinners per (Proper Name) Health Facility. (Proper Name) Health Facility states that pt is acting within her normal limits and is at baseline (as noted on above MDS, severe cognitive impairment), but they wanted to have her checked out because she is on blood thinners. Pt denies neck and back pain and refused to have a C-collar placed by EMS. Pt has no other complaints at this time. R2's same Hospital emergency room note documents R2 underwent a Computed Tomography (CT) scan of R2's head and spine, which revealed no acute changes were identified. (There was no diagnostic test or result performed on R2's right hip.) R2 was sent back to the facility. R2's discharge summary directs the facility that R2 is to return to the emergency room with new symptoms or regions of pain, red flag (serious—potentially life-threatening) symptoms. R2's Nurses Note dated 9/17/2025 at 11:51 AM documents the following: Note Text: Resident c/o right-side pain in hip and shoulder since fall. Med (medical) records from ER (emergency room) visit (9/16/2025 post fall) were reviewed, no x-rays were obtained. Resident is refusing to get out of bed with c/o pain. Spoke with resident's (V21, Family Member/POA). (V1, Administrator) ok to send out to be evaled (evaluated). Received order from (V22, Nurse Practitioner) to send to ER for c/o of increased pain in right shoulder and hip. R2's second trip from the facility to the hospital emergency room note dated 9/17/2025 documents the following: R2 was seen for the Chief Complaint: Hip and Shoulder Pain, and X-rays of R2's right shoulder and right hip were completed, and there was no acute fracture or dislocation identified. The same report further elaborates that R2's right hip X-ray does not have a True AP projection, which means the resident's anteroposterior positioning was incorrect during the X-ray diagnostic test, which can lead to image distortion. The same emergency room note documents: Consequentially, if hip pain symptoms persist, consider non-contrasted CT scan of the right hip. No further diagnostics were completed until family request on 9/29/2025 as noted below. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R2's Narcotic Count Sheet documents R2 had 26-count Tramadol (narcotic analgesic) 50 mg tablets dispensed from the pharmacy on 4/25/2025. R2 had only been administered four doses of the Tramadol supply between 4/25/2025 and 9/16/2025 (the day of R2's fall), which is indicated on the above physician order to be administered for a pain level of 7–10 (severe pain). The same Narcotic Count Sheet documents 18 doses of Tramadol were administered to R2 since her fall occurred 9/16/2025, which indicates R2 continued in severe pain after her X-ray. That X-ray, documented above as no true AP projection, and there was nothing documented that the non-contrasted CT scan of the right hip was considered, as noted in that X-ray report 9/17/2025. R2's facility facsimile to the providers dated 9/29/2025 (13 days after the fall), (Facility name) Health and Rehab Center Physician Notification, documents the following: Nursing Comments and Concerns: Resident (R2) continues to c/o (complain of) pain in R (right arm) and hip since (a) fall 9/16/2025. Family (unidentified) is concerned that she isn't using her right leg since the fall and would like to have an MRI (Magnetic Resonance Imaging) done. Specific Request: Order for MRI? (sic) Stronger pain med (medication)? (sic) Physician Comments & Signature: okay to order right hip MRI and schedule patient to be seen by me (V22, Nurse Practitioner) or (V26, Physician/Medical Director) this week. R2's Provider Progress Note, written by V22, Nurse Practitioner (NP), dated 10/01/2025, documents R2 was examined bedside. V22, NP, further documents: Recently patient had an episode of fall on 9/16/2025 and was taken to ER. She had a CT head and C-spine (9/16/2025) and hip and shoulder X-ray (9/17/2025), which was unremarkable and was sent back to SNF (Skilled Nursing Facility). Patient is complaining of ongoing right arm and right hip pain. MRI of right hip has been ordered as patient is complaining of ongoing pain and is not utilizing her right leg well. R2's Nursing Note dated 10/1/2025 at 3:36 PM documents the following: Note Text: NP (V22, Nurse Practitioner) here and seen (sic) the patient for increased pain in right hip. Patient has MRI scheduled 10/10/2025 (eleven days after the 9/29/2025 order). No new orders; we will wait for MRI results. R2's MRI of the right hip was completed on 10/10/2025 at 11:18 AM. The MRI of R2's right hip documents the Final results as an Acute, Impacted (broken pieces of the bone are wedged together tightly) Subcapital Hip Fracture With Lateral Displacement, and Extensive Soft Tissue Edema (swelling). These results were not confirmed by a radiologist until 10/11/2025 at 11:19 PM (36 hours and one minute after the MRI was completed). R2's Nursing Note dated 10/12/2025 at 4:22 PM (seventeen hours and three minutes after the late results were identified as documented above) documents the following: Note Text: (V22, Nurse Practitioner) reached out to management (unidentified), in which they reached out to this nurse (unidentified) and stated that patient (R2) needed sent to hospital due to abnormal MRI results (as noted on the MRI above). This nurse notified POA (V21, R2's Power of Attorney) and called EMS for patient transport to hospital. This nurse then called (Local Hospital) ER and gave report to (proper first-named nurse). EMS arrived and transported the patient to [NAME] Hospital for eval (evaluation). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R2's Hospital Operative Note dated 10/13/2025 documents the following: Preoperative indication:Patient is (specified age) delightful female who sustained injury resulting in fracture of femoral neck. We discussed in detail with patient and family regarding the treatment plan and complications associated with all the options. They chose to proceed with the surgical treatment plan. Treatment plan was to proceed with bipolar MI (minimally invasive) arthroplasty (hip replacement) of the right hip.Procedure performed: 1. Cemented bipolar hemiarthroplasty (surgical repair of the femoral head and neck bone) of the right hip. R2's Illinois Department of Public Health (IDPH) final report documents: Detailed Incident Summary documents the following: Final: Resident CM with PMHx of dementia, osteopenia with degeneration, cerebral infarction, COPD, heart disease, adjustment disorder with anxiety and depression, fibromyalgia, hypertension, atrial fibrillation, and anemia was sent to the emergency department on 10/12/2025 after facility received the report of resident's MRI showing an acute impacted subcapital hip fracture. This same IDPH report documents: Upon investigation, resident CM had a witnessed fall in the shower room on 9/16/2025. During shower, wheel of chair got caught on shower drain and the chair tipped forward resulting in resident fall. Resident (initials of R2) was sent to emergency department for evaluation and treatment. Resident (initials of R2) returned same day with no new orders. It was noted that the hospital completed CT of head and C-spine but no X-rays. On 9/17/2025, resident (initials R2) was continuing to have c/o pain and was sent back to emergency department for X-rays. The hospital completed 2-view X-rays of shoulder and hip w/pelvis. The results were negative for findings. Resident (initials of R2) was assessed by nurse practitioner on 9/18/2025, 9/25/2025, and 9/29/2025. On 9/29/2025, resident (R2) was given order to obtain MRI r/t resident (initials of R2) continuing to have c/o pain. Facility scheduled MRI per order for 10/1/2025 (not scheduled until 10/10/2025, ten days later). Resident (initials of R2) was assessed by nurse practitioner on 10/1/2025 and 10/9/2025. On 10/12/2025, facility received notifications r/t MRI obtained on 10/10/2025. MRI revealed an acute impacted subcapital fracture of right hip. Facility obtained orders from nurse practitioner to send resident to emergency department for evaluation and treatment of fracture. From initial fall on 9/16/2025 to facility receiving abnormal MRI results, resident (initials of R2) had no further incidents or accidents. Resident (initials of R2) was on therapy caseload and facility clinical staff as well as nurse practitioners were following resident r/t fall on 9/16/2025. Pain was being managed with both scheduled and as-needed pain medications. It is facility's determination that the root cause of the fracture is from the fall on 9/16/2025. Care plan was reviewed and intervention put into place addressing root cause of fall. Resident (initials of R2) will be assessed upon return from hospital, after being sent out on 10/12/2025. Care plan will be revised to reflect care required r/t fracture after resident assessment and review of physician's orders. This serves as final report. The facility Work Order dated as created 9/17/2025 at 9:46 AM documents:Small white shower chair wheels – North shower room.Assigned to (V18, Maintenance Director). Wheels need checked out.The same Work Order documents Updated Status dated 9/22/2025 at 9:50 AM (five days post R2's fall) by V19, Maintenance Assistant, documents: Set to Completed. On 10/15/2025 at 10:00 AM, V1, Administrator, stated, I am finishing up with (R2's) investigation. It was not an injury of unknown origin. We determined it was directly related to her fall 9/16/2025. There is too much evidence that she continued with pain in her right hip ever since the fall. It is no wonder she was having the pain. It was fractured. (continued on next page)

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	145469	A. Building B. Wing	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven of Paris	1011 North Main Street Paris, IL 61944

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/15/2025 at 11:40 AM, V13, Certified Nursing Assistant (CNA), stated V13 was giving R2 a shower in the North Hall shower room when the shower chair wheel got stuck on the drain. V13, CNA, stated he used the small, white shower chair that had wheels that never worked right. Everybody knew it. V13 said the shower chair is old, and the wheels were really worn and did not straighten out. They would turn sideways. V13 stated he was standing in front of the shower chair at the front of the stall after shutting off the water. V13, CNA, said, I tried to pull the shower chair forward out of the shower stall. The wheels turned sideways, and the back one got stuck in the drain. First, the shower chair was leaning forward. I tried to catch (R2), but then the whole chair shifted sideways and fell to the ground. (R2) hit her head and landed on her right side. (R2) immediately complained of her head, shoulder, and hip pain. The nurse came and did a complete skin assessment and sent (R2) to the hospital. (R2) came back (to the facility) the same day. I worked the next day (9/17/2025). (R2) stayed in bed, which (R2) never normally did. Her daughter (unidentified) was at her bedside. (R2) was having extreme pain. We could not shift her weight at all to move her in bed. The nurse (unidentified) gave her meds and tried to keep her comfortable (R2 was also sent to ER as noted above). The next time I worked, she was up in her wheelchair like normal. She (R2) went to the dining room per her usual. She still complained of pain at times, and the nurse would give her meds to keep her comfortable. I worked over on [NAME] (Dementia Unit) maybe twice since her fall, then was off for several days. I did hear she had a hip fracture and was in the hospital while I was off. On 10/15/2025 at 11:50 AM, V14, Certified Nursing Assistant (CNA), walked down to the North Hall shower room and confirmed there is only one small white shower chair and two white bariatric shower chairs in the North Hall shower room. V14, CNA, stated, These (two bariatric and one small) are the shower chairs that are always in the North shower room. I (V14) often will go to South (Hall) shower room and get the newer black shower chair when I give showers if it is not in use. V14 also stated, Today, I just gave a shower in this (plastic-like p-framed, small, white, wheeled) shower chair because the good one was not available. They have finally changed the wheels on this (small white shower chair). The wheels were worn and moved every which way, but not straight like they should have. The wheels don't match now, but it is better than it was with these (three matching grey and one black wheel). See the tread coming off this wheel (unmatched back black wheel)? The front ones were the worst. It is good that at least three wheels got replaced. It is much better than it was. All our shower chairs need replaced, if you ask me. The previous DON (unidentified) knew it but never had them replaced. The black one (shower chair) in South (hall shower room) is the best we have. If they (shower chairs) all functioned right, it would be nice and much safer for the residents. On 10/15/2025 at 12:20 PM, V18, Maintenance Director, walked down to the shower room on North Hall. V18 looked at the shower chair and stated three of the wheels were replaced after (R2) fell from the shower chair. We use (specific company, computer program) to get work orders from staff. We only had three wheels this (to use on the shower chair) height, so we only replaced the three. V18 then confirmed the fourth wheel's rubber tread was tattered and had one-inch tread peeled away from the tire and flapping loosely on both sides of the fourth wheel as it was rolled front and back during observation. V18 stated, This is a very old shower chair. We decided to replace what we could and picked the one (back left) in the best condition to leave on. It was It was the right height (for the shower chair). We were not told which wheel caused the resident (R2) to fall from this (shower) chair. It could have been this back one. It obviously needs replaced too. V18 then stated he has the work order, in his office computer and will provide. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/15/25 at 12:30 pm V18 walked down to the Maintenance room office to obtain the work order to fix the shower chair that resulted in R2's fall on 9/16/25. V19, Maintenance Assistant was present. While V18 searched the maintenance work orders on the computer, V19 agreed to an interview. V19 stated he could not remember how many of the wheels he replaced on the shower chair that caused R2's fall on 9/16/25. V19 stated When I lifted the chair (shower) I think all the wheels fell off. V18, Maintenance Director stated to V19, that the facility only had three wheels the right height, so we replaced three of the wheels. V19 stated That sounds right. On 10/15/25 at 2:30 pm V21, (R2's Power of Attorney) stated The facility called me when mom fell. They said she fell forward out of the shower and hit her face, shoulder and hip. She had a very large bruise on her butt and hip for a couple of weeks. It was gone by the time mom (R2) went for the MRI. Mom had been reporting to the facility nurses since her (R2's) fall (9/16/25) that she was in extreme pain. She can answer questions when asked, but not necessarily accurate. If you ask her if she is in pain and she is setting in a chair, she will say no. As soon as she would cross her legs, she would yell out to me that she was is extreme pain. The staff nurse knew this and would give her pain medicine. Finally, they did the MRI and saw the fracture in the ball of her hip. I have no idea why the MRI was scheduled so late. I think we waited for the MRI appointment two weeks (9/29/25 until 10/12/15 MRI results) after the nurses got the order for her to have that. The fracture has been fixed in surgery, now. They had to replace the whole ball in her hip joint. V21, also stated I am very happy with the care she gets in the facility. They said they were investigating how she fell. I am not sure of the details of that investigation. My concern was that she continued in so much pain. I was in to see her several times a week. It reached the point where she couldn't move her leg on her own, at all. I know she will get good care when she returns there (to the facility). Mom loves it there and I am glad of that. Therapy is very good too. On 10/15/25 at 3:00 pm V1, Administrator stated The shower chair should have been taken out of service when Maintenance was notified there were problems with the shower chair wheels, and they needed fixed. Maintenance should have said something if they couldn't do a complete wheel change. V25, Regional Nurse Consultant stated A new shower chair has been ordered since only three of the four wheels were replaced (on the small white shower chair that resulted in R2's fall). On 10/16/25 at 1:30 pm V26, Medical Director/Physician stated The resident equipment is meant to be, always maintained in a safe manner. The wheels on the shower chair are an easy fix. (R2's) fall should have never happened. It could have been easily prevented with some routine monitoring of that equipment. The facility Falls Guideline policy dated 08/2024 documents the following: Purpose: To consistently identify and evaluate residents at risk for falls and those who have fallen to treat or refer for treatment appropriately and develop an organization-wide ownership for fall prevention to: To achieve each resident's maximum potential of physical functioning. To prevent or reduce injuries related to falls. To enhance residents' dignity and self-worth. (continued on next page)

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	145469	A. Building B. Wing	10/16/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	To rehabilitate residents to their fullest potential of function. The same policy documents: The intent of this guideline is the ensure this facility provides an environment that is free from hazards over which the facility has control and provides appropriate supervision to each resident as identified through the following process: I. Identification of hazards and risks II. Evaluation III Implementation IV. Monitoring V. Analysis

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed repeatedly to maintain complete and accurate medical records for one of three (R2) residents reviewed for falls/ medical records on the sample list of three.Findings include:R2's Magnetic Resonance Imagining (MRI) report of the Right Hip was completed at a local hospital on [DATE] at 11:18 am. The MRI of R2's Right Hip documents the Final results as an Acute, Impacted (broken pieces of the bone are wedged together tightly) Subcapital Hip Fracture With Lateral Displacement, and Extensive Soft Tissue Edema (swelling). There is no documentation in R2's medical records that R2 left the faciity on [DATE] to have the MRI at the local hospital.The last documentation in R2's record was a Nurse Practitioner Note dated 10/9/2025 at 11:46 am.The next documentation was on 10/12/2025 at 4:01 pm which documents: Change of Condition /Transfer Note Text: (R2) was transferred on a gurney via ambulance to acute care hospital Sent To: (name of Local) Community Hospital Date: 10/12/2025 16:10 Sent From: (Name of the facility) Healthcare Center Unit: North Wing. Reason(s) for Transfer: Other - Abnormal MRI results MD (unidentified) notified of transfer. See Transfer Form for other details.R2's current Physician Order Sheet (POS) documents the following: Tramadol HCL (narcotic analgesic) Oral Tablet, 50 Milligrams (mg), Give 1 tablet by mouth every 12 hours as needed for pain 7-10.R2's same POS documents: Pain Assessment - every shift using 1-10 Scale (scale of ten, being the worst pain level).R2's Narcotic Count Sheet documents R2's had 26 count of tablets; Tramadol (narcotic analgesic) 50 mg tablets dispensed from the pharmacy on 4/25/25. R2's had been administered four doses of the Tramadol supply between 4/25/25 and 9/16/25 (the day of R2's fall). The same Narcotic count sheet documents 18 doses of Tramadol were administered to R2, since her fall occurred 9/16/25. All doses signed out on the narcotic count sheet, correlate with the Medication Administration Record (MAR) records documented below except, the following doses were removed from R2's supply on 9/19/25 at 7:00 am, 9/28/25 at 8:00 am or 8:00 pm, 9/29/25 at 8:00 pm and 10/9/25 at 8:00 pm.R2's corresponding Medication Administration Record (MAR) dated 9/16/25 through 9/30/25 and R2's MAR dated 10/01/25 through 10/12/25 do not document R2 received Tramadol HCL (narcotic analgesic) Oral Tablet, 50 mg on 9/19/25 at 7:00 am, 9/28/25 at 8:00 am or 8:00 pm, 9/29/25 at 8:00 pm and 10/9/25 at 8:00 pm.R2's same MAR documented above fail to document R2's pain level scores as ordered: Pain Assessment - every shift using 1-10 Scale (scale of ten, being the worst pain level). On 10/16/25 at 11:55 am V2, Director of Nursing (DON) reviewed R2's Tramadol (narcotic analgesic) 50 Milligram (mg) tablet, Controlled Drug Administration, narcotic count sheet. V2 confirmed, according to R2's narcotic count sheet that R2's Tramadol 50 mg tablets, were removed the supply, from the locked compartment on the medication cart, on 9/19/25 at 7:00 am, 9/28/25 at 7:00 am and 8:00 pm, 9/29/25 at 8:00 pm, and 10/9/25 at 8:00 pm. V2, DON then reviewed R2's Medication Administration Records (MAR). V2, DON acknowledged R2's MAR does not document R2 was administered the Tramadol 50 mg tablets on the documented dates noted. V2, DON stated I am confident the Tramadol was given for (R2's) pain. I reviewed (R2's) records yesterday (10/15/25) and realized the nurses failed to document on the MAR's, that (R2's) Tramadol was given (9/19/25 at 7:00 am, 9/28/25 at 8:00 pm, 9/29/25 at 8:00 pm, and 10/9/25 at 8:00 pm). I confirmed with those nurses (unidentified) that it (Tramadol) was given. They just forgot to document on the MAR. V2, DON further reviewed R2's Medication Administration Records and confirmed that nurses had been signing off that they completed the pain assessments each shift but failed to complete the documentation by not identifying the level of pain on the scale of 1-10, 10 being the most severe. V2 DON also confirmed R2's went out to the hospital via ambulance for an MRI on 10/10/25, and the nurses failed to documents her leaving and returning the facility. V2, DON stated I am new to the facility and new to the Director of Nursing position. This will be addressed. It is Nursing 101 to document accurately and completely in the resident's medical record.