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	10/28/2025

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 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adequate supervision for a resident with Lewy Body Dementia to prevent a fall for one (R1) of three residents reviewed for falls on a sample list of three. This failure resulted in R1 falling to the ground and sustaining an acute fracture of the left hip. Findings include:The facility's 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 achieve each resident's maximum potential of physical functioning, to prevent or reduce injuries related to falls, to enhance residents' dignity and self-worth, to rehabilitate residents to their fullest potential of function. This policy also documents that the intent of this guideline is to 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: identification of hazards and risks, evaluation, implementation, monitoring, and analysis.On 10/28/2025 at 10:12 AM, R1 was lying flat on his back with his head propped on a pillow and his left arm was in a sling. R1 stated, I have pain in my (groin area) on the left side. R1 did not remember that he had a fall and broke his left hip.R1's electronic medical record documents R1 has a diagnosis of Neurocognitive Disorder with Lewy Bodies and R1's Care Plan dated 9/19/2022 documents R1 has impaired cognitive function or impaired thought processes related to neurocognitive disorder with Lewy Bodies.R1's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status score of five indicating R1 has severe cognitive impairment.R1's Fall Risk assessment dated [DATE] documents R1 is at high risk for falls.R1's Care Plan dated 5/18/2023 documents that R1 has the potential risk of elopement related to cognitive deficit, history of wandering, and walking about aimlessly without purpose. R1's Care Plan dated 8/23/2025 with a revision on 9/02/2025 documents that R1 is at risk for falls related to impaired cognition, poor safety awareness, dementia, shuffling gait, and weakness and at risk for falls with injury related to medications, history of falling, poor balance, unsteady gait, and weakness.R1's Progress Notes dated 8/30/2025 document that R1 had an unwitnessed fall that resulted in R1 sustaining a fracture to his left shoulder, a laceration on the side of his left eye, and a skin tear to R1's left elbow. The facility Fall Investigation for R1's 10/18/25 fall #1830 (10/24/2025) documents a witness statement dated 10/18/2025 from V7 (Certified Nurse Assistant (CNA)) which states, I was filling out paperwork at the desk and then I got up to go to the bathroom and (saw) that (R1) was walking out of his bathroom and begin to lose balance and went down to the floor.R1's Hospital Discharge summary dated [DATE] documents R1 was admitted to the hospital following a mechanical fall at the facility (on 10/18/25) where R1 resides and R1 sustained a left hip fracture. An x-ray report dated 10/18/2025 confirmed that R1 had an acute intertrochanteric fracture of the left femur with soft tissue swelling. In a phone interview on 10/27/2025 at 12:26 PM, V7 CNA stated (on 10/18/25) she was standing at the nurses' station and looked up and noticed R1 coming out of R1's neighbor's room, V7 CNA stated R1 lost his balance and fell. V7 CNA stated, I don't know what time the fall happened or the last time I saw (R1), and I don't have anything else to tell you.On 10/272025 at 1:13 PM, V4 (Registered Nurse (RN)) stated she was taking care of R1 the day of R1's fall (on 10/18/25). V4 stated R1 has dementia, was alert and oriented to person only and frequently would get up on his own. V4 RN stated the CNAs should have been checking R1 every two hours if not more frequently.R1's EMR (Electronic Medical Record) documents R1 was last repositioned at 8:22 AM on 10/18/25. R1's Progress Notes document R1 fell on [DATE] at 3:50 PM. On 10/27/2025 at 2:24 PM, V9 (Licensed Practical Nurse (LPN)/MDS Coordinator) stated, 15-minute checks (increased visuals) are implemented for those residents that have been determined to wander or who are at risk for elopement. On 10/27/2025 at 11:39 AM, V6 (Certified Nurse Assistant (CNA)) stated that R1 frequently gets up on his own without calling for help.On 10/28/2025 at 10:05 AM, V8 CNA stated that R1 is oriented to person only and gets up on his own frequently to get coffee and that is how he fell the first time (8/30/25). On 10/28/2025 at 10:21 AM, V3 (LPN/Assistant Director of Nursing (ADON)) stated that CNAs are responsible for checking residents that are at increased risk for falls every two hours and that it is a task in the EMR where they document those checks. V3 LPN stated residents that are a high risk for falls or high elopement risk should be checked on every 15 minutes. V3 stated the CNAs should have been checking on R1 at minimum every two hours and that it should be documented. V3 LPN could not provide documentation showing R1 had been checked on appropriately on