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	11/13/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based observation, interview, and record review the facility failed to protect the resident's right to be free from physical abuse by another resident. This failure affects two of four residents (R2 R3) reviewed for abuse in the sample list of eight. The facility's undated Abuse Prevention Policy documents that the facility affirms the right of their residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse neglect, exploitation, misappropriation of property and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of resident.This will be done by establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; identifying occurrences and patterns of potential mistreatment; identifying concerns of residents; implementing systems to promptly and aggressively investigate all reports and mistreatment and making the necessary changes to prevent future occurrences.This policy defines abuse as any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain and/or maintain physical, mental, and psychosocial well-being. This assumes that all instances of abuse of residents even those in a coma, cause physical harm or pain or mental anguish. The term willful in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical Abuse is the infliction of injury on resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. The facility investigation file dated 11/10/25 documents on 11/09/25 at approximately 10:18 AM, R3 was sitting on her walker, waiting in line to go out and smoke when R2 came up from behind and grabbed R3's shoulder. V15 (Occupational Therapist (OT)) overheard R3 yelling and when V15 OT approached R3, R3 reported that R2 had hit her in the shoulder. V15 OT reported this to V6 (Registered Nurse (RN)). This report also documents that R8 was a witness to the incident and R8 reported that while waiting to go out and smoke R2 wheeled up behind R3 and grabbed her right shoulder and R3 started yelling at R2 to stop touching her. V6 RN separated R2 and R3 and both residents were assessed by V6 RN. This report documents that the facility moved R2 to a secured unit, updated R2's Care Plan, and educated staff on behavior management.R3's Minimum Data Set (MDS) documents that R3 has normal cognitive function. R3's Electronic Medical Record (EMR) documents the following diagnoses: Legal Blindness, Major Depressive Disorder, History of Traumatic Fracture, Type 2 Diabetes mellitus with Hyperglycemia and Diabetic Neuropathy, Asthma, Chronic Obstructive Pulmonary Disease, Hallucinations, Cord Compression, Spinal Stenosis, History of Transient Ischemic Attack, Cerebral Infarction, Hypertension, and History of Alcohol Abuse.R2's undated Care Plan documents diagnoses including Unspecified Dementia, Unspecified Severity, With Other Behavioral Disturbance, and Post Traumatic Stress Disorder. The Care Plan documents R2 has behaviors related to diagnosis of dementia, and history of Post Traumatic Stress Disorder. The Care Plan documents R2 has episodes of being physically aggressive toward others, and that R2 is resistant to care with new intervention dated 7/25/25 to increase supervision and resident will be placed on 10-minute checks.On 11/10/25 at 11:12 AM, R3 stated she was sitting on her four wheeled walker yesterday and waiting in line to go out to smoke and put on her brakes to her walker before standing up. R3 stated that when she stood up and turned around R2 was in her face and punched her in the right shoulder. R3 stated she was scared, and her first reaction was to hit him back, but she didn't and instead told him Don't touch me, don't you ever touch me again. R3 stated R2 said I told you I was coming! R3 stated it doesn't matter what he thinks he told me; he should never touch me.On 11/13/25 at 9:41 AM, R8 confirmed that he witnessed the incident on 11/09/25 between R2 and R3. R8 stated R3 was sitting on her walker next to him and they were waiting to get their cigarettes before they went outside to smoke. R8 stated R2 came up behind R3 and firmly, with an open hand grabbed R3's right shoulder. R8 stated R3 was mad as can be and shocked that R2 touched her. R8 stated R3 snapped at R2 to stop touching her and R2 backed off. R8 stated this wasn't the first time the facility has had this kind of trouble with R2. R8 stated R2 has attempted to

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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)

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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 develop and implement interventions and provide supervision to prevent a wandering resident from entering other resident's rooms invading resident privacy, disturbing the environment, taking assistive devices, and making inappropriate comments for five (R1, R5, R6, R7, R8) of five residents reviewed for accidents on a sample list of eight. This failure resulted in R1 falling on two separate occasions when R2 took R1's walker and sustaining a laceration to the knee requiring six sutures, a laceration to the left hand and a hematoma to the scalp. Findings include: R2's undated Care Plan documents diagnoses including Unspecified Dementia, Unspecified Severity with Other Behavioral Disturbance and Post Traumatic Stress Disorder (PTSD). The Care Plan documents R2 has behaviors related to diagnosis of Dementia, and history of PTSD. The Care Plan documents R2 has episodes of being physically aggressive towards others and that R2 is resistant to care with new interventions dated 7/25/25 to increase supervision and that R2 will be placed on 10-minute checks.R2's document titled 15 Minute Checks documents as follows: 11/4/25 blank from 6:15 AM to 5:45 PM, 11/7/25 blank from 6:15 PM to 11:45 PM, 11/10/25 no documentation, and 11/11/25 blank from 12:00 AM to 3:45 AM and 8:45 AM to 11:45 PM.R2's Progress Note dated 10/20/25 documents R2 raised a fist and swung at another resident because the other resident was in R2's way.R2's Progress Note dated 10/30/25 documents R2 wandering into other resident rooms without permission. R2 redirected. Behavior continues.R2's Physician Visit Note dated 11/10/25 documents R2 has Dementia, requires redirection and cuing for safety, and that R2 is impulsive and has poor safety awareness. The Note documents R2 was recently in the hospital for acute psychiatric services and R2 is now on therapy services. The Note documents R2 is inconsistent and difficult to redirect at times and R2 has frequent behaviors.R1's Care Plan, undated, documents R1 is [AGE] years old with an admission date of 7/28/25. The Care Plan documents R1 is independent with bed mobility, transfers, and toileting. The Care Plan documents R1 has diagnoses that include heart disease, atrial fibrillation, osteoporosis, low back pain, bilateral lower limb swelling, lump/mass, and that R1 is taking blood thinners. R1's Progress Notes dated 11/1/25, document R1 was found on the floor with her head resting on the table that her refrigerator sits on. A laceration was noted to the left hand. Resident was alert and oriented times four and denied any pain other than her hand. The Progress Notes document R1 stated that she hit her head during the fall. The Progress Notes document Emergency Medical Services were notified.R1's progress notes do not document a fall on 11/4/25.R1's Hospital Records dated 11/1/25 and 11/4/25 document R1 was sent to the emergency department for falls in the early morning hours on 11/1/25 and 11/4/25. On 11/1/25 hospital records document R1 was discharged at 4:02AM with a laceration of the finger of the left hand, hematoma of the scalp and fall. On 11/4/25 hospital records document R1 was discharged at 4:50AM with a laceration of left knee and a head injury. The facility investigation file dated 11/4/25 documents on 11/4/25 at approximately 0200 AM, R1 had an unwitnessed fall in R1's room related to walker not in reach of resident. The investigation documents R1 was attempting to toilet self when legs gave out. R1 alert and oriented times four. R1 hit R1's head on the bedside table next to the recliner where R1 was found by staff post fall. The investigation documents R1 did not have proper footwear on at the time of the incident and was not utilizing an assistive device. The investigation documents R1 was sent to the Emergency Department for complaints of knee pain and pain to left side of face. R1 returned to the facility with sutures to the left knee. The investigation file documents a new fall intervention of -- placed sign in room to remind R1 to use walker when ambulating. On 11/10/25 at 10:58 AM, R1 was observed walking from the bathroom to the recliner using a rolling walker and wearing non-skids socks. R1 had a large purple area across R1's forehead and a purple area across the bridge of R1's nose. R1's cheek was swollen and pink. R1's left palm was purple throughout with a laceration to R1's 5th finger.At 11:00 AM on 11/10/25, R1 stated that when she went to the bathroom, the first time she fell on [DATE], R2 entered her room and moved her walker out of reach over by her bed and was sitting on her bed trying to tear apart her call light. R1 stated that R2 proceeded to tell her when he was done with the call light, he was going to put her in bed and have sex with her. R1 stated she screamed for help, but no one came to her aide. R1 stated the second time she fell on [DATE], R2 was in her room again and moved her walker out of reach while she was in the bathroom. R1 stated this fall caused her to hit her head and receive six stitches to her knee. R1 stated she is fearful of R2 and that he was in her room last night on 11/9/25 as well. R1 stated R2 is always