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	04/09/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect a resident's right to for privacy. This failure affected two of three residents (R1, R6) reviewed for quality of care on the sample list of six. Findings Include: The facility's Resident rights Guideline policy dated October 2023 documents the facility will treat each resident with respect and dignity, and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. All residents have the right to equal access to quality care regardless of a diagnosis, severity of a condition, or payment source. Each resident has the right to privacy and confidentiality as well as a safe environment for themselves and their personal possessions. The facility must take reasonable care to protect personal property from loss or theft. 1. R1's Medical Diagnoses List dated April 2026 documents R1 is diagnosed with Alzheimer's Disease and Vascular Dementia with Behavioral Disturbances. R1's Minimum Data Set, dated [DATE] documents R1 is severely cognitively impaired and requires supervision or touching assistance for transfers. R1 uses a walker and wheelchair for mobility. R1's Progress Notes dated 2/24/26 documents a resident (R2) entered R1's room and sat in R1's recliner. R1 yelled out, What the h*** (expletive)? This is my room, go on and get before I stand up! Please keep that damn lady out of my room. I feel like I have no privacy anymore! On 4/8/26 at 12:15 PM V3 (R1's Wife) stated R2 is constantly wandering the halls and comes into R1's room. R2 will sit on his bed or in his recliner and wander in and out. V3 stated R2 wanders in and out of other people's rooms as well and staff are not doing enough to protect the residents from R2's intrusions. On 4/9/26 at 10:36 PM V12 Registered Nurse (RN) stated R2 is always wandering into R1's room. V12 RN stated V3 told her she doesn't want to come to the facility to see R1 anymore because she is tired of R2 always coming into R1's room. 2. R6's Medical Diagnoses List dated April 2026 documents R6 is diagnosed with Cognitive Communication Deficit, Dementia, Psychotic Disturbance, Mood Disturbance, and Anxiety. R6's Minimum Data Set, dated [DATE] documents R6 has mild cognitive impairment and independent with transfers and mobility with a walker. On 4/9/26 at 11:20 M R6 stated she is tired of R2 coming into her room and she had to place a Stop sign on her door and keep her door closed to protect her things and have privacy. Staff had attempted to remove her soaps and lotions in order to keep R2 from getting into them, however since they returned them to R6. On 4/9/26 at 10:36 AM V12 Registered Nurse stated R1 is constantly wandering into other resident's rooms. On 4/9/26 at 11:25 AM V13 Registered Nurse stated R2 wanders often and will pick things up as she goes in and out of other resident's rooms. V13 stated R6 has a lot of personal items and has gotten very upset when R2 is in her room. V6 must keep her door closed and a stop sign on her door to help detour R2 from entering into V6's room uninvited. On 4/9/26 at 1:00 PM V1 Administrator confirmed that it is hard for staff to provide adequate supervision for R2 who often wanders in and out of other resident's rooms. V1 confirmed the facility will have to figure out a better way to provide better supervision for R2 so that she does not impede the privacy of other residents or take other resident's things.

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 - Minimal harm or potential for 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 interview and record review the facility failed to provide adequate supervision for a resident who wanders. This failure affected one of three residents (R2) reviewed for quality of care on the sample list of six. Findings Include: The facility's undated Nursing Services Policy documents it is the policy of the facility that each resident shall receive nursing care and supervision to obtain and maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessments, plan of care, physician's orders and accepted standards of nursing practice. It is the facility's responsibility to ensure that each resident is provided nursing care and supervision based on their needs. Staff are to provide care in a manner in which the resident is treated with respect, dignity and afforded privacy. R2's Medical Diagnoses List dated April 2026 documents R2 Diagnosed with Major Depressive Disorder, Generalized Anxiety Disorder, and Insomnia. R2's Minimum Data Set, dated [DATE] documents R2 is severely cognitively impaired and is independent with transfers and requires supervision with walking. R2 often wanders and has had physical behavioral symptoms directed towards other residents such as hitting, pushing, and grabbing. R2's Care Plan documents R2 is at risk for elopement related to exit seeking behavior, a history of elopement and wandering. R2 wanders into other resident's rooms where she is not welcome. R2 is at risk for abuse related to invading other's space and rummaging through other resident's belongings. R2 is physically vulnerable and has dementia, confusion, poor judgment, and wanders frequently in and out of other's spaces. R2's Nurses Notes dated 2/22/26 documents R2 wandered into another resident's room several times. The other resident (unknown) threatened to throw R2 out of their room if she comes in there again. On 4/8/26 at 12:15 PM V3 (R1's Wife) stated R2 is constantly wandering the halls and comes into R1's room. R2 will sit on his bed or in his recliner and wander in and out. V3 stated R2 wanders in and out of other people's rooms as well and staff are not doing enough to protect the residents from R2's intrusions. V3 stated she does not feel like staff are providing enough supervision for R2. On 4/8/26 at 12:40 PM V5 Activity Aide stated R2 often goes into other residents' rooms and wanders back and forth in the halls. On 4/8/26 at 12:45 PM V6 Certified Nurse's Assistant stated R2 goes into other resident's rooms and upsets them. R2 gets yelled at sometimes by the other residents and will occasionally lay in other people's beds. On 4/8/26 at 12:50 AM V8 Certified Nurse's Assistant stated R2 wanders up and down the halls and in and out of resident's rooms. On 4/9/26 at 10:36 PM V12 Registered Nurse (RN) stated R2 is always wandering into R1's room. V12 RN stated V3 told her she doesn't want to come to the facility to see R1 anymore because she is tired of R2 always coming into R1's room. V12 Registered Nurse stated R1 is constantly wandering into other residents' rooms. R2 will sit on other residents' bed, chairs, or stand and look out the windows in their rooms. On 4/9/26 at 11:20 M R6 stated she is tired of R2 coming into her room and she had to place a Stop sign on her door and keep her door closed to protect her things and have privacy. On 4/9/26 at 11:25 AM V13 Registered Nurse stated R2 wanders often and will pick things up as she goes in and out of other resident's rooms. V13 stated R6 has a lot of personal items and has gotten very upset when R2 is in her room. V6 must keep her door closed and a stop sign on her door to help detour R2 from entering into V6's room uninvited. On 4/9/26 at 1:00 PM V1 Administrator confirmed that it is hard for staff to care for other residents while trying to provide adequate supervision for R2 who often wanders in and out of other resident's rooms. V1 confirmed the facility will have to figure out a better way to provide better supervision for R2.