

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/16/2025
NAME OF PROVIDER OR SUPPLIER  The Haven of Ridgeview		STREET ADDRESS, CITY, STATE, ZIP CODE  413 Ridge Lane Oblong, IL 62449	

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 - 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.  (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide an environment free of accident hazards for 1 (R1) of 3 residents reviewed for accidents in the sample of 6. Findings include: R1's admission Record documented an admission date of 5/30/2025 and diagnoses including lymphedema, not elsewhere classified, cellulitis, unspecified type 2 diabetes mellitus without complications and cerebral palsy, unspecified. R1's Minimum Data Set (MDS) dated [DATE], documented under section C-Brief Interview for Mental Status (BIMS) of 14, which means R1's is cognitively intact. This same document under section GG- Mobility that R1 is dependent, which means helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort for a chair/bed-to chair transfer. R1's care plan documented a focus area of lymphatic ulcer of the left 2nd toe related to lymphedema and needs assistance with activity of daily living (ADLs) related to weakness, Cerebral Palsy, mechanical lift transfer. On 9/24/2025 at 10:47 AM, R1 stated on the evening of 9/11/2025, she did hit her left lower leg on her bed frame. R1 stated, V7 (Certified Nurse Assistant/CNA) and V8 (CNA) had assisted her to her room via wheelchair. R1 stated V7 had been unable to get her turned around to be ready for the mechanical lift transfer and her legs were elevated in her wheelchair. R1 stated when V7 had been trying to turn her around in the wheelchair, her left leg went under her bed and hit the bed frame on the right side. R1 stated there had been no black cap covering the square end of the frame and the sharp edge broke her skin open. R1 stated she had been sent to the local emergency room for further evaluation via ambulance. On 9/24/2025 at 12:34 PM, V4 (Wound Nurse) stated she did not work the night of 9/11/2025. V4 stated she did receive a phone call from V6 (Licensed Practical Nurse/LPN) asking her to come into the facility to assess R1. V4 stated V6 notified her that she had received a skin tear to her left lower leg during a transfer. V4 stated she arrived at the facility to assess R1. V4 stated after her assessment she notified V6 to send R1 to the local emergency room for further evaluation. V4 stated she left the facility after R1 had been sent to the local emergency room but was aware that R1 received one stitch place to the skin tear. On 9/24/2025 at 1:26 PM, V6 stated she had been the nurse working the floor on 9/11/2025 when R1 had an incident. V6 stated V7 (CNA) told her that R1 had contacted the right side of the bed frame with her left leg and caused it to bleed in the process of trying to position her for a chair to bed transfer. V6 stated there had been no black cap on the end of the bed frame, and it had sharp edges. V6 stated R1 did return to the facility that evening with 1 stitch in place and orders to keep the area dry, an antibiotic was started and stitch to be removed in 3-5 days. On 9/24/2025 at 1:38 PM, V7 (CNA) stated she had been working on 9/11/2025 when R1 had caught her left leg on her bed. V7 stated her and V8 (CNA) were in the process of getting ready to transfer R1 from her wheelchair to her bed via mechanical lift. V7 stated she tried to reposition R1 in her wheelchair by backing her up and at that time her left leg made contact with the right side of the bed frame and started to bleed. On 9/24/2025 at 1:47 PM, V8 (CNA) stated she had been working on 9/11/2025 when R1 had caught her left leg on her bed. V8 stated her and V7 (CNA) were in R1's room getting her ready for a transfer from her wheelchair to her bed with a mechanical lift. V8 stated she had been standing in front of the wheelchair and V7 had been standing behind the wheelchair. V8 stated V7 went to reposition R1 when her left leg made contact with the right side of her bed frame. V8 stated R1's bed frame on the right side did not have a black cap on the end of it and the edges were sharp. On 9/24/2025 at 1:56 PM, V2 (Director of Nursing/DON) stated she had been notified by V6 (LPN) via phone that R1 had been sent to the local emergency room for further evaluation because she had made contact with her left leg to her bed frame causing a laceration during a transfer. On 9/25/2025 at 9:49 AM, observed dressing change to R1 completed by V14 (Registered Nurse/RN) with assistance from V15 (RN) and V16 (Physical Therapy Assistant/PTA). Observed left lower left leg laceration in the process of healing. On 9/25/2025 at 10:44 AM, V1 (Administrator) stated, she had been notified via phone by V6 (LPN) that R1 had been sent out to the local emergency room on the evening of 9/11/2025 because she had hit her leg on her bed frame. V1 stated the next day in the morning meeting it was discovered that there had been a black cap missing from the bed frame on R1's bed and it was replaced. R1's Progress Note by V4 (Wound Nurse) dated 9/11/2025 at 7:18 PM documents R1 had been sent out to the local emergency room for a skin tear to left lower leg related to resident's lymphedema. R1's Local Emergency Physician Note dated 9/11/2025 documented R1's chief complaint as patient stated that leg got caught in bed at facility and suffered a significant skin tear laceration. This same document under History of Present Illness documented</p>		