STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146096	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven of Ridgeview	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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a working call light for one resident of three residents (R1) reviewed for call lights in the sample of 15.Findings include:R1's Face Sheet documented an admission Date of 4/8/25 and listed Diagnoses including Hemiplegia and Hemiparesis of the left side following a CVA (Cerebral Vascular Accident), Diabetes Type 2, and Hypertension. R1's Minimum Data Set, dated [DATE] documented that R1 had minimal deficits in cognition and was dependent on staff for transfers and toileting. R1's Care Plan dated 11/13/25 documented a problem area, Self-care deficit as evidenced by needs assistance with ADLs (Activities of Daily Living), toileting related to weakness, CVA, right foot amputation, with a corresponding intervention, Encourage the resident to use bell to call for assistance.On 12/4/25 at 11:05am, R1 was observed in his room after having been transferred via mechanical lift from the wheelchair to the bed. V2, Director of Nurses, was present. When the Surveyor pointed out her observation that R1 did not have a call light, V2 acknowledged this and stated R1 is capable of using his call light. V2 stated the solution to this would be R1 asking his roommates, R2 and/or R3, to activate their call lights for R1, and that R2 had in fact done so. When the Surveyor asked R2 about this, R2, who was alert to person and place but not time, stated he was not sure.On 12/4/25 at 12:30pm, V9, family member of R3, stated if R1 were to ask R3 to push the call light, R3 would not hear him as R3 is severely hearing impaired.On 12/9/25 at 1:30pm, R1 was alert and oriented to self only. When asked what he would do in the event he needed help from staff, R1 stated he was not sure, he guessed he would lay there until somebody came to help him.On 12/11/25 at 10:50am, V1, Administrator, stated when R1 was moved into the room on 11/28/25, staff should have ensured he had a working call light. V1 stated as of 12/4/25 after the surveyor's observation that R1 did not have a call light, R1 was given a call light.The facility's Answering the Call Light Policy dated August 2008 documented, The purpose of this procedure is to respond to the resident's requests and needs. 4. Be sure the call light is plugged in at all times. 5. When the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident. 7. Report all defective call lights to the Maintenance Department promptly. 10. call lights must be accessible to residents from their bed or other sleeping accommodation. Call lights must be accessible to residents from each toilet and bath or shower facility. The call system should be accessible to a resident lying on the floor.

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