

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 08/14/2025
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 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 observation, interview, and record review the facility failed to allow residents to smoke at the times they chose for 1 (R26) of 5 residents reviewed for smoking in a sample of 32. The Findings include: R26's admission Record documented an admission date of 11/22/24 with diagnoses including peripheral vascular disease, unspecified, chronic kidney disease, vitamin D deficiency, personal history of transient ischemic attack and cerebral infarction, and anxiety disorder, unspecified. R26's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R26 was cognitively intact. R26's Safe Smoking Screening dated 5/3/2025, documented under cognition, has the following questions marked no: Does the resident exhibit signs of confusion? The following questions were marked yes on this same form: Does the resident have the ability to make himself/herself understood? Can the resident verbalize or demonstrate an understanding of the living center's smoking policy? Can the resident verbalize or demonstrate an understanding of the living center's times and place to smoke? Does the resident remain alert during the course of smoking at all times? Is the resident able to communicate the need for help if lit materials fall on them? On 08/13/2025 at 9:57 AM, R26 stated she is independent and would be able to open the door on her own if given the code to get outside. R26 stated, that she is upset about not able to go outside by herself for smoking, especially when they miss a scheduled time to go outside to smoke. On 08/11/2025 at 1:30 PM, V4 (Social Services Director/SSD) stated she does complete the smoking evaluations on residents. V4 stated the resident is screened for independent or needs supervision, but all resident in the facility is supervised at this time. V4 stated R26's current safe smoking assessment dated [DATE] documented she can do everything by herself and is independent. On 8/11/2025 at 2:00 PM, V3 (Regional Director) stated all residents are supervised during smoking times even if they are deemed independent on their smoking assessments. On 8/11/2025 at 1:20 PM, R26 was observed sitting in her wheelchair in her room applying makeup. R26 was observed self-propelling wheelchair in room. On 08/12/2025 at 11:30 AM, R26 was observed self-propelling wheelchair outside for smoke time with supervised smoke break. R26 had been handed her cigarettes and lighter from V4 (SSD). R26 observed lightening own cigarette and distinguishing cigarette in a safe manner. The facility Smoking Policy (revised 3/10/25) documented under Policy: To provide a safe and healthy living environment with respect for the health, well-being and personal choice of each resident, staff member and visitor.		

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on Interview and Record Review, the facility failed to provide Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNFABN-CMS10055) for 1 of 3 residents (R5) reviewed for Beneficiary Protection Notification in the sample of 32. The Findings Included: R5's admission Record documented an admission date of 6/18/2025 with diagnoses including: osteomyelitis of vertebra, sacral and sacrococcygeal region, type 2 diabetes mellitus without complications, chronic kidney disease, and essential hypertension. R5's Skilled Nursing Facility Beneficiary Protection Notification Review form documents a discharge from Medicare Part A services prior to exhaustion of his benefit day allotment and a last covered day of Part A Services of 5/6/25. This form documents that a written notice of the resident's potential liability for a non-covered stay (SNFABN - CMS10055) form was not provided to R5 to explain his right to appeal the decision of discharge from Medicare Part A services prior to exhaustion of her benefit days. 08/12/2025 12:19 PM, V13 (Regional Social Services) stated R5 had not been notified because the facility had been in between business office managers, and it was missed. On 08/12/2025 at 12:47 PM, V1 (Administrator) stated the facility does not have a policy for advanced beneficiary notices. V1 stated the facility follows the CMS (Centers for Medicare & Medicaid Services) guidelines.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility to ensure residents were free from abuse for 2 of 2 (R3 and R47) resident reviewed for abuse in the sample of 32. The findings include: The Verification of Incident Investigation/Administrative Summary dated 06/06/2025 documents an incident type of Alleged Resident to Resident with an incident date of 6/1/25. Under the summary of investigation findings it documents A comprehensive investigation was initiated and showed that staff reported that one resident (R47) with a BIMS (Brief Interview for Mental Status) of 08 had kicked resident (R3) BIMS of 05 in the knee. Upon interview neither resident could recall the incident or that even anything had ever happened. Neither resident showed any adverse effects of the incident. Other alert and oriented residents were interviewed and had no concerns regarding abuse or harm coming from staff or other residents. Medical record review reveals resident (R47) is currently being treated for a UIT [sic] (Urinary Tract Infection) with all physician orders processed and being carried out. The allegation of willful physical abuse is unsubstantiated. Under Individuals with direct knowledge of incident/event and/or those interviewed it documents the names of R3, R47, and V9 (Certified Nurse Assistant/CNA). Under Immediate Action Taken this summary documents, Residents were immediately separated. Both residents were assessed and interviewed. MD (physician) and POA (Power of Attorney) were notified. Local PD (Police Department) was notified. IDPH (State Survey Agency) office was notified, Ombudsman was notified. R3's Transfer/Discharge Report with a print date of 8/13/25 documents R3 was admitted to the facility on [DATE] with diagnoses that include unspecified glaucoma, osteoarthritis, and unspecified dementia. R3's MDS (Minimum Data Set) dated 5/20/25 documents R3 has a BIMS (Brief Interview for Mental Status) score of 05, indicating a severe cognitive deficit. R3's current Care Plan documents a Focus area of (R3) has a psychosocial well-being problem r/t (related to) 06/01/2025 - Res (resident) to res, (R3) was kicked in knee by another Resident. Date Initiated: 06/02/2025. This Focus area documents the following interventions, Encourage participation from resident who depends on others to make own decisions. Date Initiated: 06/02/2025 .Provide opportunities for the resident and family to participate in care. Date Initiated: 06/02/2025. R47's Transfer/Discharge Report with a print date of 08/12/2025 documents R47 was admitted to the facility on [DATE] with diagnoses that include bipolar disorder, insomnia, major depressive disorder, and unspecified dementia. R47's MDS dated [DATE] documents a BIMS score of 09, indicating a moderate cognitive deficit. R47's current Care Plan documents a Focus area of (R47) has potential to be physically aggressive AEB (as evidenced by) history of resident to resident altercations. Date Initiated: 01/24/2025. This Focus area documents the following interventions, Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document .Due to past physical aggression, (R47) has a motion sensor alarm above her door to notify staff when (R47) is leaving her room On 08/10/2025 at 09:38AM, R3 stated she was kicked in the leg and she kicked them back. R3 showed this surveyor her leg and there was no obvious signs of injury. R3 was not able to provide this surveyor with any other information. On 08/12/2025 at 10:29 AM, V1 (Administrator) stated R3 and R47 used to be roommates. V1 stated after the altercation they moved R3 to a different hall. V1 stated R47 doesn't ambulate and R3 is ambulatory. On 8/14/2025 at 12:01 PM, this surveyor reviewed the abuse investigation with V1 (Administrator) and asked her why she didn't substantiate abuse. V1 stated she believed the reason she didn't substantiate abuse was because neither resident remembered it occurring. This surveyor asked about the staff member (V9/Certified Nursing Assistant) who witnessed it and V1 stated she didn't think she witnessed them make physical contact. V1 then read through the witness statement included in the investigation and stated it documents V9 saw R47 kick R3. V1 stated she didn't substantiate the allegation because neither resident remembered it occurring and both residents had dementia. The facility Abuse Policy (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 10/24/22 documents, Purpose: To provide guidance and Procedures to the facility and staff to assure the residents remain to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. Responsibility: The administrator and/or designee is the facility abuse coordinator for the facility. It is the responsibility of all facility staff to assure that all residents remain to be free from abuse, including injuries of unknown origin, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. it is all staff responsibility report any allegation or witnessed abuse Immediately to the Administrator (Abuse Coordinator).		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide activities that meet the interest of the residents and ensure quarterly activities assessments were completed for 1 of 1 (R9) resident reviewed for activities in the sample of 32. Findings Include: R9's Transfer/Discharge Report with a print date of 8/14/25 documents R9 was admitted to the facility on [DATE] with diagnoses that include unspecified dementia. R9's Minimum Data Set, dated [DATE] documents a Brief Interview for Mental Status score of 10, indicating R9 has a moderate cognitive deficit. R9's current Care Plan documents a Focus area of, Activity Interests/Preferences: visiting with family, being outside when the weather is nice Date Initiated: 01/01/2025. This Focus area includes interventions of, Encourage and support the development of a new skill, interest, or hobby Give directions prn (as needed) .Provide any needed supplies and assistance for activities R9's Activity Initial assessment dated [DATE] documents under Past Activity Interest, being outside when weather is nice, visiting with family. This assessment documents R9 does not wish to participate in group activities, go on outings, or want 1:1 with staff. This same assessment documents the following accommodations, reminders of activities, encouraging her to attend, large print, sitting closer to activity to be able to hear well. R9's electronic health record does not document an activity assessment after 1/2/2025. On 08/10/2025 at 12:35 PM, V14 (Family Member) stated R9 likes to do crafts/paintings and he had spoke with staff about getting these activities for her and nothing had happened. On 08/14/2025 at 11:20 AM, V1 (Administrator) stated V4 (Activities Director/AD) was off work for a family emergency. V1 stated they do preference/activities assessments on all the residents. V1 stated they didn't have an AD for a short time and those assessments weren't completed until V4 stated in June or July. On 08/14/2025 at 11:49 AM, V13 (Resident Services) stated the AD position was open until they hired V4, who started on 6/20/25. V13 stated the activities assessments are done upon admission, quarterly, and then annually. V13 stated she gave V4 direction to complete the assessments as the MDS's came due and they did not have a quarterly assessment completed for R9. The facility policy titled Activity Assessment dated 5/10/23 documents, Purpose: To provide staff with guidance to ensure resident preference in activities are met. Policy: In order to promote the physical, mental and psychosocial well-being of residents, an activity evaluation is conducted and maintained for each resident at least quarterly and with any change of condition that could affect his/her participation in planned activities 1. An activity assessment is conducted as part of the comprehensive evaluation to help develop an activity plan that reflects the choices and interests of the resident.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide restorative nursing services including assessments and care planning for 1 of 2 residents (R43) reviewed for restorative nursing services in the sample of 32. Findings include: R43's Transfer Sheet documented an admission Date of 7/18/17 and listed Diagnoses including Parkinson's Disease, Diabetes Type 2, and Atherosclerosis of Native Arteries of Extremities, Bilateral Legs. R43's Minimum Data Set, dated [DATE] documented that R43 has minimal deficits in cognition, and requires supervision or touching assistance for ambulation. R43's Physical Therapy Discharge summary dated [DATE] documented, Patient progress: Progress and response to treatment: Patient made substantial functional gains in response to skilled interventions. Patient responded positively to passive techniques to stimulate functional performance and enhance safety to prevent further decline, and patient's functional abilities have progressed as a result of skilled interventions. Long term goal: Patient will safely ambulate on level surfaces 50 feet using (trade name walker) with supervision or touching assistance with functional dynamic balance and with functional posture to facilitate increased participation in functional activity. (Goal was) met on 7/4/25. Discharge reason: Highest practical level/maximum potential achieved. Discharge recommendations: Patient is to be discharged to this facility with recommendations of staff to provide assist as needed and participation in restorative nursing program/functional maintenance program to provide carry over of progress and to maintain current functional status. Restorative program established/trained: Other restorative program: Patient would benefit from continuous activity including strengthening and ambulation to maintain current functional status. R43's Care Plan dated 7/31/25 documented a problem area, (R43) has a decline with bilateral lower extremity (specify: leg, knee, foot, toes specify digits: first, second, third, fourth, fifth) related to: joint mobility. This problem area did not document any interventions related to ambulation. R43's Point of Care Response History documentation for July and August 2025 documented that the only day in that period when R43 was ambulated three times daily was 7/15/25, and there were no refusals documented in that period. On 8/10/25 at 10:14am, R43 was alert and oriented to person, place, and time. R43 stated, They (staff) are supposed to be walking me to every meal, but they're not. On 8/12/25 at 10:15am, when asked if R43 is on a restorative nursing program, V12, Certified Nursing Assistant (CNA), stated the facility does not employ restorative nurses or Restorative CNA's, but the CNA working with R43 that day should walk her to each meal unless she refuses, which she sometimes does. On 08/12/2025 at 1:47 PM, V1, Administrator, stated the facility does not currently have a restorative nursing program, but they are in the process of getting services back in place now with new administration in the building. V1 confirmed R43 is to be walked to dine at each meal. When asked about the documentation in R43's record showing she is not being ambulated three times daily, V1 stated she thinks the CNA's are doing it, but they don't know how to chart refusals or that they should chart refusals. On 08/13/2025 at 11:13 AM, when asked if R43 gets any restorative nursing services, V9, CNA, stated R43 is supposed to be walked to dine for every meal, three times daily. V9 stated sometimes in the morning when they have to get everybody up and out to breakfast, it's hard to find the time to do it, and sometimes if R43 is having a bad morning, she will refuse. V9 stated R43 should be approached about walking prior to each meal, and if she refuses, it should be documented in the CNA charting with the time of the refusal. On 08/13/2025 at 11:27am, V10, Physical Therapy Assistant, stated R43 made progress in therapy, achieved maximum possible benefit, and was discharged with the recommendation that nursing staff walk her to each meal. V10 stated she has observed CNA staff doing this but does not know if it is happening consistently. On 08/14/2025 at 9:54am, V5, Minimum Data Set/Care Plan Coordinator, stated she started in the position in July of 2025 and is still in training. V5 stated next week her training is to begin on adding restorative nursing services to the care plan. A Restorative (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Program/Range of Motion Policy dated 2/3/22 documented, Purpose: To provide resident with limited range of motion, appropriate treatment, and services to increase or prevent further decrease in range of motion. Responsibility: It is the responsibility of the nurse who completes the quarterly Restorative Assessment to identify a resident's need for range of motion exercise. It is the responsibility of the CNA to perform exercises as identified. It is the responsibility of the Care Plan Coordinator for addressing the Care Plan. On 08/14/2025 at 11:44am, V1 stated the facility has not been doing quarterly Restorative Assessments as per the facility's policy but will begin doing so.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review the facility failed to ensure that residents had alternative meal options similar or equivalent nutritive value of the main meal selection for 3 of 3 residents (R25, R42, and R46) reviewed for nutrition in a sample of 32. The Findings Include: On 8/10/2025 at 12:29 PM, V7 (Cook) was observed serving residents their lunch meal that included herb roasted pork loin, herb stuffing, green beans and peach crisp from the steam table in the dining room. V7 was observed not serving the vegetable green beans or cream corn on R42, R46 and R25's trays. On 8/10/2025 12:40 PM, R42 was observed sitting in the dining room eating a regular mechanical soft diet that included ground herb roasted pork loin with gravy and soft herb stuffing with gravy and peach crisp. There were no vegetables observed on R42's lunch tray. On 8/10/2025 at 12:42 PM, R46 was observed being served a CCHO (Controlled Carbohydrate Diet) mechanical soft diet that included ground herb roasted pork loin with gravy and soft herb stuffing with gravy and peach crisp. There were no vegetables observed on R46's lunch tray. On 8/10/2025 at 12:45 PM, R25 was observed in the dining room eating a regular mechanical soft diet that included ground herb roasted pork loin with gravy and soft herb stuffing with gravy and peach crisp. There were no vegetables observed on R25's lunch tray. On 8/10/2025 at 12:44 PM, V7 (Cook) stated R42, R46 and R25 do not like green beans. V7 stated, she does not know what is supposed to be served in place of green beans if the residents do not like them. On 8/10/2025 12:44 PM, V6 (Dietary Manager) stated any resident who does not want green beans should have been served the alternative vegetable of cream corn. On 8/11/2025 12:07 PM, V8 (District Dietary Manager) stated any resident that does not like the vegetable being served that day, should be offered the alternative vegetable for the day. The facility meal cards for R42, R46 and R25 does not document a dislike of green beans. The facility policy titled Food Preference and Portions dated (issued 09/01/2021) documented under Guidelines. 3. The Food Preference Interview will be entered into the medical record. 4. Food allergies, food intolerance, food dislikes and food and fluid preferences will be entered into the resident profile in the menu management software system. 7. The individual tray assembly ticket will identify all food items appropriate for the resident/patient based on diet order, allergies and intolerances and preferences. 8. Upon meal service, any resident/patient with expressed or observed refusal of food and/or beverage will be offered an alternate selection of comparable nutrition value.		

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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 ensure residents were equipped with a working call light for 1 of 1 residents (R27) reviewed for call lights in the sample of 32. Findings Include: R27's Transfer/Discharge Report with a print date of 8/12/25 documents R27 was admitted to the facility on [DATE] with diagnoses that include osteoporosis, chronic obstructive pulmonary disease, atrial fibrillation, contracture of left lower leg, major depressive disorder, and malignant neoplasm. R27's Minimum Data Set, dated [DATE] documents a Brief Interview for Mental Status score of 15, indicating R27 is cognitively intact. R27's current Care Plan documents a Focus area of (R27) has Self-Care Deficit as Evidenced by: Needs (extensive) assistance with ADL's (Activities of Daily Living) Related to impaired mobility, weakness. Date Initiated: 01/12/2023. This Focus area includes the intervention, Encourage the resident to use bell to call for assistance. Date Initiated: 01/12/2023. On 08/10/2025 at 10:36 AM, R27 was sitting in bed, there was a cow bell noted sitting on the table located next to R27's bed. R27 stated the facility staff took his call light and gave it to his roommate a couple of weeks ago. R27 stated they gave him the cow bell and he can call the facility from his phone. R27 stated this happened a couple of weeks ago. On 08/13/2025 at 11:19 AM, V9 (Certified Nursing Assistant/CNA) stated she was aware R27 had a cow bell to use instead of a call light. V9 stated she wasn't sure why R27 didn't have a call light, she guessed it wasn't working. This surveyor walked with V9 to R27's room and there was a cow bell present on his over the bed table located next to his bed and no call light present near his bed. On 08/14/2025 at 10:41 AM, V1 (Administrator) stated the button on R27's call light broke and when they tried to order a replacement light the type they need has been discontinued. V1 stated they have a call out to a technician who has ordered the part and as soon it comes in he will replace the call system in that room. When asked if they had that scheduled for repair yet, V1 stated she would have to check on the date. V1 stated in the meantime R27 has his cell phone that he uses and he had been care planned to call the facility if he needed assistance and he had a cow bell in his room that he can use. After reviewing R27's current Care Plan, this surveyor asked V1 where the intervention to use his cell phone and cow bell was located at on the Care Plan. V1 stated it was just added to the care plan this morning. The facility Call Light Guidance Policy dated 8/20/22 documents, Purpose: To provide guidance to all facility staff on the use, response and placement of call lights Procedure: 1. When initiated, the system will light up in the room, outside the room and on a central panel. An audible sound will also be engaged. 2. A call light activation device shall be kept within resident reach while in resident rooms and bathrooms 4. The call light activation device shall be appropriate for resident's condition. Alternative buttons, pads, etc. may be utilized when warranted.		