Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDIGHT	PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:						
		IL6002950	B. WING		C 01/06/2021		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
FAIR HA	FAIR HAVENS SENIOR LIVING 1790 SOUTH FAIRVIEW AVENUE						
		DECATUR	R, IL 62521				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLE		
S 000	Initial Comments		S 000		ĺ		
	Complaint Investiga	ation #20610040/IL129800		υ:	į.		
S9999	Final Observations		S9999				
	Statement of Licen	sure Violations:					
	300.610 a) 300.3240 a) 300.3240 e)			\$2			
	a) The facility procedures govern facility. The written be formulated by a Committee consist administrator, the a medical advisory of nursing and other policies shall comp. The written policies the facility and shall comp.	advisory physician or the committee, and representatives or services in the facility. The ly with the Act and this Part. It is shall be followed in operating the reviewed at least annually documented by written, signed					
	employee or agent neglect a resident. e) Employee a an investigation of a resident indicates evidence, that an e facility is the perperent employee shall important with pending the outcomprosecution or discontinuous.	Abuse and Neglect icensee, administrator, of a facility shall not abuse or as perpetrator of abuse. When a report of suspected abuse of a, based upon credible imployee of a long-term care trator of the abuse, that inediately be barred from any iresidents of the facility, ine of any further investigation, iplinary action against the		Attachment A Statement of Licensure Violation	S		
Illinois Depa LABORATOR	rtment of Public Health Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE		

STATE FORM

6899

PZ0W11

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7. BOILDING			С	
		IL6002950	B. WING			06/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
FAIR HAVENS SENIOR LIVING  1790 SOUTH FAIRVIEW AVENUE  DECATUR, IL 62521							
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	IION .	(ME)	
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 1	S9999				
	employee.						
	These regulations a	are not met as evidenced by:					
	Based on interview failed to prevent mis resident's(R1) properties abuse prevent misappropriation of failed to perform an check. R1 is one of misappropriation in failure resulted in \$100 charges being madimmediately following Findings include:  R1's Face Sheet (unadmitted to the facility on 11/24/R1's credit card states.)	and record review, the facility sappropriation of erty, failed to operationalize ion policy by failing to prevent a residents's (R1) credit card, complete investigation, and employment background of three residents reviewed for the sample of three. This 1747.99 of unauthorized e to R1's credit card accounting R1's death in the facility.					
	to 12/3/2020, include totaling \$1747.99 be after R1's death in the documents 11 of the local city and four or at a gas station local comments V3 (R1's the facility on 12/29, were made to R1's of the facility.	ling 22 unauthorized charges eginning the day immediately he facility. The same record at 22 charges were made in a fithe 22 charges were made at 40.4 miles from the facility. The Report Form (1/5/2020) is Representative) reported to 1/2020 unauthorized charges credit card while a resident of					
=		0:15AM, V3 reported it card on 12/2/2020, and then					

Illinois Department of Public Health

Illinois Department of Public Health							
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
					C		
		IL6002950	B. WING		01/0	6/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE			
EVIE HV	ZENS SENIOR LIVING		TH FAIRVIE	W AVENUE			
FAIRDA	VENO OFFICIAL FILLIAN	DECATUR	, IL 62521				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)		(X5) COMPLETE DATE	
\$9999	Continued From pa	ige 2	S9999				
	12/16/2020, and not following R1's death V3 reported R1 worth anyone to use R1's On 12/31/2020 at 1 (Administrator) info facility thought they R1's credit card.	0:15AM, V3 reported V1 rmed V3 on 12/29/2020 the knew what staff member took					
	Nursing) reported be charges following F facility thinks the staken R1's card was Nurse). V2 was no	8:08PM, V2 (Director of cased on the R1's credit card R1's death in the facility, the aff member who may have as V5 (Licensed Practical of aware if V5 was suspended the of the facility investigation initiated credit card.				i.	
	Director) reported fromplete a propert documenting a resistant brought with them facility. At 1:15PM, had an Inventory Radmission, or if factor R1 following V3 credit card theft an reported if a reside held by the facility, resident's property	ident's personal property upon their admission to the , V8 reported not knowing if R1 lecord completed at the time of ility staff attempted to find one is report to the facility of R1's d unauthorized use. V8 Int declines to have property then staff will chart the being kept by the resident, e or whoever admits the					
	horrified, it is awful That is a new low,	7PM, V3 stated, "I am that someone would do that. the fact that the day after (R1) spending on (R1's) credit card."		8			

Illinois Department of Public Health

(X3) DATE SURVEY

Illinois Department of Public Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:			COMPLETED	
						3	
		IL6002950	B. WING		01/0	06/2021	
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
FAIR HA	FAIR HAVENS SENIOR LIVING 1790 SOUTH FAIRVIEW AVENUE						
	DECATUR, IL 62521						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
S <b>9</b> 999	Continued From pa	ge 3	S9999			±8	
	having R1's credit of death in the facility.  On 1/4/2021 at 2:05 stated, "I am not su Inventory Record of admission and if the R1's electronic med not done by facility process for handling ask to inventory the to keep the property the facility.	5PM, V2 (Director of Nursing) re" if R1 had a property completed at the time of R1's re Inventory Record is not in lical record, it probably was staff." V2 reported the facility g a resident's credit card is to reproperty if the resident wants y in their possession while at					
	determined V5 was misappropriated cre	edit card because many of the es were made at locations in a					
i	retrieving R1's pers	AM, V9 (R1's friend) reported onal property from the facility and noting R1's wallet did edit card.					
	have any outside vis		**				
	transporting R1 to tl	PM, V7 (R1's friend) reported he facility for admission on rted R1 possessed R1's the admission.					
	(undated) did not co	electronic medical record ontain any property Inventory by charting documenting R1's	:				

(X2) MULTIPLE CONSTRUCTION

Illinois Department of Public Health

PZ0W11

PRINTED: 02/09/2021 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ B. WING IL6002950 01/06/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1790 SOUTH FAIRVIEW AVENUE FAIR HAVENS SENIOR LIVING DECATUR, IL 62521 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S9999 Continued From page 4 S9999 property at the time of admission. The facility Final Incident Report (1/5/2021) does not document the suspicion or investigation of V5 in relation to R1's credit card misappropriation. V5's personnel file (undated) does not document any background employment checks for V5 prior to V5's employment at the facility. On 1/4/2020 at 3:45PM, V2 stated V5's personnel file was complete (containing all personnel records related to V5's employment at the facility). Employee work schedules (undated) document V5 actively worked in the facility from 11/20/2020 to 11/30/2020. On 1/4/2021 at 2:05PM, V2 reported V5 did provide care to R1 during V5's employment with the facility. The facility Abuse Prevention Program Policy (undated) documents: "Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This includes but is not limited to corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms." The same record documents the facility will complete pre-employment screening of employees. The facility Background Screening Investigations policy (12/2006) documents: "The

Illinois Department of Public Health

Personnel/Human Resources Director, or other designee, will conduct employment background checks, reference checks and criminal conviction checks (including fingerprinting as may be required by state law) on persons making

application for employment with this facility. Such investigation will be initiated in accordance with

employment or offer of employment." The same

state regulatory guidelines pertaining to

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PRO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		IL6002950	B. WING			C 06/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
FAIR HA	VENS SENIOR LIVING	9	ITH FAIRVIE R, IL 62521	EW AVENUE		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO- DEFICIENCY)	D BE	(X5) COMPLETE DATE
\$9999	record also docume professional applyir involve direct conta respective licensing	ents: "For any licenseding for a position that may ct with residents, his/her position be contacted to nctions have been assessed	S9999	DEFORMOTY		

Illinois Department of Public Health