

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Fairhaven Christian Ret Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3470 North Alpine Road Rockford, IL 61114	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20042</p> <p>Based on interview and record review, the facility failed to ensure R1 was supervised while eating and food items were present within R1's reach. This failure resulted in R1 choking on R1's food and expiring. This applies to 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 3.</p> <p>This failure resulted in an Immediate Jeopardy.</p> <p>The Immediate Jeopardy began on [DATE] at 6:00 PM, when facility staff failed to ensure R1 was supervised at the dining room table when food was present. R1 impulsively grabbed food, put it in her mouth, choked, and died .</p> <p>The facility was notified of the Immediate Jeopardy on [DATE] at 9:28 AM. V1 (Administrator) was informed of the Immediate Jeopardy on [DATE] at 9:28 AM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on [DATE]; however, noncompliance remains at a Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.</p> <p>Findings include:</p> <p>The Face Sheet dated [DATE] for R1 showed diagnoses including Alzheimer's disease, fracture of neck, type 2 diabetes mellitus, vascular dementia moderate, with psychotic disturbance, deep vein thrombosis, delusional disorder, anxiety, tremors, muscle weakness, and cerebellar stroke syndrome.</p> <p>The Progress notes for R1 showed on [DATE] at 12:27 PM, during lunch resident was having a difficult time swallowing her food (stringy meat) as evidenced by coughing/choking during the meal. Residents' food was cut up into very small pieces and message was left for hospice to return a call to the facility to further discuss the resident's diet. At 2:15 pm, verbal orders received from hospice to downgrade resident's diet to mechanical soft texture. POA (Power of Attorney) contacted and in agreement with diet change orders. Diet slip completed and submitted to dietary.</p> <p>The Physician Orders for R1 showed on [DATE] an order was entered for a general, mechanical soft diet.</p> <p>(continued on next page)</p>

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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Progress Notes for R1 showed on [DATE] at 10:37 PM, at 6:00 PM R1 was in the dining room eating supper. A CNA (Certified Nursing Assistant) was sitting beside her. R1 was so fast eating her supper that made her choke. She was already turning blue. She was unresponsive. Did Heimlich maneuver. We brought her to her room and did some suctioning. We were able to get some pieces of food. Resident was grimacing when I was pinching her fingers. At 6:11 PM called the POA and informed him that resident was unresponsive and informed him about what happened. At 6:23 PM, resident was no longer breathing. Vital signs have ceased and eyes fixed. Pronounced death of resident at 6:23 PM. Hospice was notified and said she would call all the parties concerned.</p> <p>The facility's Incident Report Telephoned to Regional Office form (no date) showed, Date of Incident: [DATE]; Time of Incident: 6:00 PM. Name of patient/Resident: (R1). Describe what happened, causes(s), injury: Upon investigating it was determined that the resident (R1) was sitting at her regular seat where she was served a general/regular meal for supper on [DATE]. On [DATE] the resident's diet order was changed to mechanical soft. At 6:00 PM the resident began to choke. Staff immediately responded with back blows and Heimlich maneuver. The resident was assisted to her room and the Heimlich was continued. The resident went unconscious and was assisted to bed. Suction was attempted. At 6:11 PM, the POAHC (Power of Attorney for Healthcare) was called and requested hospice be notified instead of sending the resident out. Hospice was notified at 6:18 PM .oxygen saturation 89% on room air, 3 liters of oxygen applied. At 6:23 PM the resident was pronounced deceased . All parties notified. On [DATE] a full investigation took place.</p> <p>On [DATE] at 10:35 AM, V8 (Food Service Supervisor) stated, one of our (dietary) staff was passing plates for supper on Thursday night. We were serving pulled pork sandwiches. She got confused; R1 was supposed to have ground meat and got pulled pork instead. V13 Dietary Aide gave the wrong diet to R1. V13 gave pulled pork instead of the ground meat which is mechanical soft.</p> <p>On [DATE] at 1:28 PM, V14 Server stated, I remember someone came in (to kitchen) and said a resident was choking and turning blue. When I came back from break the nurse said R1 ate too fast, choked, and died .</p> <p>On [DATE] at 1:39 PM, V15 Dietary Aide stated she was told that R1 was choking, and someone was helping her. Later the nurse came in with a card and said R1 was dead. V13 didn't know R1 was on a mechanical soft diet and gave her a regular diet. She got bigger pieces than she should have, and it caused her to choke on the food.</p> <p>On [DATE] at 3:34 PM, V3 CNA stated she gave R1 a bite of food and heard another CNA tell one of her other residents to sit down so she went over to check on that resident. V3 stated when she was checking the other resident, R1 started choking. The nurse came over and tapped R1 on the back. Two other CNAs came over and rushed R1 to her room. V3 stated sometimes R1 would have to be fed and sometimes not; she was able to do finger foods herself. V3 stated R1 ate fast so if they fed her, she would slow down when eating.</p> <p>On [DATE] at 3:46 PM, V5 CNA stated she was with the nurses when they tried to help R1. They tried to do the Heimlich and tried to suction R1. V5 stated R1 has choked before; she would eat too fast and cough it up. V5 stated most of the time R1 would eat too fast so someone needed to be with her monitoring that.</p> <p>(continued on next page)</p>		

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