STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E345	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairhaven Christian Ret Center	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506 Based on observation, interview, and record review the facility failed to ensure ADL (Activities of Daily Living) assistance was provided for two of 16 residents (R54, R27) reviewed for ADL care in the sample of 16. The findings include: 1. R54's Face sheet shows she was admitted to the facility on [DATE] with diagnoses including dementia, anxiety disorder, delusional disorder, restlessness and agitation. R54's Care Plan dated June 12, 2023 shows R54 was frequently incontinent of bladder and bowel. I need staff assistance with incontinence cares and my hygiene needs. Observe me for verbal and non verbal cues that I need to use the toilet. R54's MDS (Minimum Data Set) dated December 2, 2024 shows R54 is not cognitively intact, R54 required partial/moderate assistance with toilet hygiene, and was dependent on staff for toilet transfers. R54 is occasionally incontinent of bowel and bladder. On January 6, 2025 at 8:47 AM, R54 was observed sitting in the television room in her wheel chair. R54 was observed in the same spot until 9:19 AM. At 9:19 AM, V17 and V7 CNAs (Certified Nursing Assistants) used a stand lift to transfer R54 into a gray recliner. R54 was observed continuously from 9:41 AM-11:44 AM. During this time, R54 was observed being restless: leaning forward in the recliner, trying to get up from the recliner, and removing her blankets multiple times. At 10:41 AM, V7 gave R54 a snack. At 10:43 AM, another staff member asked R54 where she was going and told R54 she had to stay in the recliner. At 10:47 AM, another staff member went to R54 and asked R54 where she was going and covered R54 back with the blanket. R54 was mumbling non sensical words. At 10:55 AM, V7 sat with R54. At 11:18 AM, V7 went to lunch. Another staff member check in with R54 at 11:27 AM. At 11:44 AM, R54 was attempting to stand up again. R54 was transferred into her wheel chair at 11:44 AM. At 11:50 AM, V10 and V11 (CNAs) transferred R54 onto the toilet in her room. V11 removed R54's incontinence brief. R54's incontinence brief was saturated with dark urine from front to back of the brief. R54's buttocks was reddened and had creases in it. 2. R27's Face Sheet shows she was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, dementia, urinary tract infection, dysuria, delusional disorders, restless legs syndrome, muscle weakness, overactive bladder, and major depressive disorder. (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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R27's Care Plan dated November 22, 2017 shows, Provide toileting assistance as needed. R27's MDS (Minimum Data Set) dated December 16, 2024 shows R27 is not cognitively intact, requires substantial/maximal assistance with toileting, and is dependent on staff for toilet transfers. R27 is occasionally incontinent of bowel and bladder. On January 6, 2025 at 8:48 AM, R27 was observed in a high back wheeled recliner feeding herself breakfast. At 9:07 AM, R27 was moved into the television room. At 9:15 AM, R27 was transferred into a recliner. At 9:40 AM, R27 was observed sleeping in the same recliner until 11:45 AM when R27 was transferred into her wheelchair. At 11:47 AM, R27 was brought into the dining room for lunch. At 12:04 PM, R27 was being fed lunch. At 12:53 PM, R27 was placed back into the television room. At 1:01 PM, V10 (CNA) said she was not sure when she was going to perform peri care for R27. At 1:17 PM, V9 and V10 (CNAs) transferred R27 onto the toilet. R27's incontinence brief had urine in it. V10 said that R27 is usually continent. On January 8, 2025 at 9:04 AM, V2 (DON-Director of Nursing) said that incontinence care/toileting should be performed at least every two hours, unless the resident is cognitive enough to tell staff when they have to use the bathroom. The facility's Perineal Management-Peri Care policy dated January 24, 2007 show perineal care is done to promote cleanliness and comfort and to reduce infection potential by removing irritating secretions or excretions, microorganisms, and offensive odors.

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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. 37232 Based on observation, interview, and record review the facility failed to ensure a splint was placed for a resident with limited range of motion for 1 of 2 residents (R51) reviewed for range of motion in the sample of 16. The findings include: A facility assessment done on 11/18/24 showed R12 had limited range of motion to his upper extremity. On 01/06/25 at 08:51 AM, there was a sign above R51's bed. The sign indicated that a splint was to be placed on R51's right hand in the mornings. The initial wear time was 1-2 hours and progressing to wearing the split all day. The sign was dated 11/29/24. There was a blue splint sitting in the chair next to R51's bed. On 01/06/25 at 10:49 AM, R51 was in bed. There was no splint on R51's right hand. The splint remained sitting on the chair. R51's right hand was in a closed fist. R51 was asked if he could open his right hand. R51 could not open his right hand. On 01/06/25 at 1:12 PM and 2:27 PM, the splint remained off. On 01/07/25 at 9:10 AM, R51 was sitting in the common area in a chair. R51 did not have a splint on. On 01/07/25 at 9:10 AM, V3 (Certified Nursing Assistant- CNA) said she was familiar with R51. V3 said she was not sure if R51 used a splint and referred the surveyor to V4 (CNA assigned to V51). On 01/07/25 at 9:15 AM, V4 said restorative was responsible for placing the splint on R51's right hand. On 01/07/25 at 9:41 AM, V5 (Restorative CNA) said R51 was not on any restorative programs and restorative was not putting R51's splint on. On 01/07/25 at 9:44 AM, V6 (Rehabilitation Director) said occupational therapy was seeing R51 two times a week for a contracted right hand. According to V6, the last time occupational therapy worked with R51 was 12/31/24 (7 days ago). V6 said R51 was on a splinting program. V6 added that the floor CNAs or restorative staff were responsible for placing the splint on the days occupational therapy did not see R51. R51's Progress Note dated 11/21/24 showed occupational therapy plan of care was for splinting of R51's right wrist to maintain joint mobility. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R51's Progress Note dated 12/02/24 showed occupational therapy updates was for R51's splint to be placed on the right hand in the morning with an initial wear time 1-2 hours and to progress to all day wear. R51's Care Plan with a start date of 12/2/24 showed R51 required a right hand splint daily.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506 Based on interview and record review, the facility failed to ensure a significant medication error did not occur for one of one resident (R28) reviewed for significant medication error in the sample of 16. The findings include: R28's Face Sheet shows she was admitted to the facility on [DATE] with diagnoses of congestive heart failure, urinary tract infection, diabetes mellitus, generalized anxiety disorder, edema, atrial fibrillation, supraventricular tachycardia, cardiac pacemaker and hypotension. R28's Progress Note dated November 28, 2024 at 12:00 PM shows, Resident was given wrong medication by agency nurse this am. Writer informed DON (Director of Nursing) and on call nurse practitioner (NP) about this situation. NP ordered vitals every 30 minutes for two hours, then every hour for four hours. Give midodrine if blood pressure (BP) drops below 90. Resident started to exhibit symptoms of low BP. Writer checked BP and then administered midodrine as directed. Residents BP has since gone up to normal ranges. 3:17 PM, Writer couldn't keep resident BP up, NP said to send resident to emergency room . R28's Vital Results dated November 28, 2024 at 8:38 AM, shows her blood pressure was 123/67. At 10:17 AM, R28's blood pressure was 75/42. At 10:42 AM, R28's blood pressure was 87/52. At 11:10 AM, R28's blood pressure was 109/60. At 1:12 PM, R28's blood pressure was 75/43 and at 1:40 PM, R28's blood pressure was 77/51. R28's After Visit Summary from the local emergency room dated November 28, 2024 shows R28 was seen in the emergency room for a medication overdose. The facility's Medication Error Report dated November 28, 2024 shows, Description of error (include name of medication, dose, route, and time administered. Amlodipine (high blood pressure medication) 2.5 mg + 5 mg to equal a total of 7.5 mg, aspirin 81 mg, calcium D3 500 mg, hydralazine (high blood pressure medication) 50 mg, losartan (high blood pressure medication) 100 mg, magnesium 400 mg, omeprazole 20 mg, potassium 10 meq, vitamin E, and Vitamin B complex. Outcome of resident: BP 75/42 heart rate 75. Received orders for midodrine 10 mg is BP drops <90. Corrective action taken: Sent to emergency room to be evaluated and update power of attorney. On January 8, 2025 at 9:47 AM, V2 (DON-Director of Nursing) said an agency nurse was looking for R44 in order to administer R44's medications. The agency nurse asked V15 (LPN-Licensed Practical Nurse) who R44 was and V15 pointed to who R44 was. V2 said that the agency nurse gave R44's medications to R28. V2 said that R28 and R44 sit at the same table for meals. V2 said that the nurses have pictures of the residents on their computers which should be checked prior to administering medications. V2 said staff should be verifying resident names, picture, medication, right person, right dose, right time, and right route prior to administering medications. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On January 8, 2025 at 10:10 AM, V15 (LPN) said she was working with an agency nurse when that nurse asked V15 who R44 was. V15 said she pointed to R44. V15 said the nurse acknowledged who R44 was. V15 said a dietary aide came to V15 and asked why R28 had thickened liquids in front of R28. V15 said that R44 is the one that should have thickened liquids in front of her so V15 said Oh my gosh, she gave the wrong medications. V15 said the nurses are the ones that provide the thickened liquids. V15 said she went up to R28 and asked R28 if the agency nurse gave her medicine and R28 said yes. V15 said that R28 is cognitively intact. V15 said she ran to the medication cart and told the agency nurse that she gave the medications to the wrong resident. V15 said she notified the doctor and the Director of Nursing. V15 said the nurse practitioner said it was ok to not give R28 her regular scheduled medications. V15 said that R28's blood pressure was dropping. (R28 received high blood pressure medications that were not ordered for her). V15 said she was monitoring R28 frequently. V15 said the nurse practitioner gave orders to give R28 a medication to increase her blood pressure if her blood pressure decreases, so V15 did that and R28's blood pressure increased. V15 said there was staff sitting with R28 offering her fluids. V15 said that R28 reported to V15 that she was feeling funny so V15 ran in and took R28's blood pressure again and R28's blood pressure had dropped again so V15 notified the nurse practitioner again. The nurse practitioner told V15 to lay R28 in bed and to elevate R28's feet. V15 said that R28 told her that R28's vision was blurry. V15 said R28 was more lethargic and more dizzy than normal. V15 said that at this time, R28's blood pressure only went up a little bit so V15 was told to send R28 to the local emergency room . R28's Progress Notes dated November 29, 2024 at 1:39 AM shows, R28 returned from the local hospital at approximately 7:30 PM (November 28, 2024). R28's blood pressure was within normal limits. R28 stated she was feeling better. The facility's Medication Incident/Event Policy and Procedures dated 2023 shows, Purpose: To safeguard the resident and provide emergency care as necessary. The facility must ensure that its residents are free of any significant medication errors.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 33760 Based on observation, interview and record review the facility failed to ensure a multidose vial was labeled and dated when opened. This failure has the potential to affect all residents at the facility. The findings include: On 1/7/25 at 8:38 AM, this surveyor and V2 (Director of Nursing-DON) checked the 2nd floor medication room in the Healthcare Services Unit. A multidose vial of Tubersol (tuberculin (TB) testing solution) was noted in the refrigerator opened but not labeled with the date of opening. The preprinted date labeled on the vial was 9/16/24. V2 (DON) said this (vial) is months old, it should have been disposed of after 28-30 days. V2 said the Tubersol vial was used to all residents including new admits and any residents needing yearly TB testing including staff. V2 said any multidose vial should be dated and labeled once opened. The facility Policy titled Multi dose vial medication management dated 11/10/24 shows, 3. When a multi dose vial is opened, the nurse is required to complete sticker with the following- date of opening the vial, expiration date 28 days from opening or the manufacturer's expiration date whatever is sooner. Nurse initials when placing the sticker. The CMS report dated 1/6/25 show there were 63 residents residing at the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37232 Based on observation, interview, and record review the facility failed to ensure staff used the required personal protective equipment (PPE) when entering COVID-19 isolation rooms and failed to ensure N95 masks were not worn over a surgical mask. The facility also failed to ensure gloves were changed to prevent cross contamination. This applies to 5 of 16 residents (R12, R10, R45, R54, and R27) reviewed for infection control in the sample of 16. The findings include: 1. R12's progress note dated 01/06/25 indicated R12 was on isolation for COVID-19. On 01/06/25 at 8:35 AM, there were signs on R12's room door indicating R12 was on airborne isolation, droplet isolation, and contact isolation. On 01/06/25 at 12:29 PM, V8 (Housekeeper) put PPE on to enter R12's room. V8 entered R12's room with gloves, gown, and a surgical mask on. V8 did not have on a N95 mask or eye protection. On 01/06/25 at 12:42 PM, V8 exited R12's room and stated she cleaned the room. V8 said she knows what PPE to wear when entering an isolation room based on the signs on the door. The signs on R12's door indicated a N95 mask and eye protection were required. On 01/07/25 at 10:04 AM, V16 (Infection Control Nurse) said the required PPE for entering a resident's room on isolation for COVID-19 was gown, glove, N95 mask, and goggles. 2. On 01/06/25 at 8:35 AM, V7 (Certified Nursing Assistant) had R12's meal tray and placed on PPE to enter R12's room. V7 had a surgical mask on under a N95 mask when entering R12's room. On 01/07/25 at 10:04 AM, V16 said a surgical mask should not be worn under a N95 mask. 33760 3. On 1/6/25 at 8:30 AM, R10 and R45's room was closed with a sign on the door of droplet and contact precautions. V12 (License Practical Nurse) said both R10 and R45 were on isolation due to positive for Covid 19. R10's result detail show R10 is positive for Covid 19. R45's result detail show R45 is positive for Covid 19. At 9:15 AM, V14 (Certified Nursing Assistant-CNA) was in the room with gown, gloves and surgical mask on and brought R10 and R45 their breakfast. V14 stayed in the room to monitor both residents while eating their breakfast. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 1:15 PM, V14 (CNA) said while she was in R10 and R45's room, she applied an N95 mask over her surgical mask when she realized she was only wearing a surgical mask. V14 said she removed the N95 mask before she exited the room. On 1/7/25 at 8:35 AM, V13 (CNA) said she was the Covid CNA today. V13 was in R10 and R45's room with no PPE (no gown, no N95 mask and no eye protector). V13 said she removed her surgical mask and N95 mask, gown and faceshield while she was still in the Covid positive room since she was planning to leave the room shortly. On 1/8/25 at 11:15 AM, V2 (DON-Director of Nursing) said the facility is on Covid 19 outbreak. All staff providing care to Covid 19 positive residents should wear gown, gloves and N95 mask. Staff cannot put a surgical mask under the N95 mask. The facility policy on Preventing the spread of Covid 19 show, the facility will implement al three types of transmission based precaution-contact, droplet and airborne. PPE use will include:gloves, gown and N95 respirators and eye protection. 34506 4. R54's Face sheet shows she was admitted to the facility on [DATE] with diagnoses including dementia, anxiety disorder, delusional disorder, restlessness and agitation. R54's Care Plan dated June 12, 2023 shows R54 was frequently incontinent of bladder and bowel. R54 needs staff assistance with incontinence cares and her hygiene needs. Observe R54 for verbal and non verbal cues that I need to use the toilet. On January 6, 2025 at 11:50 AM, V10 and V11 (CNAs-Certified Nursing Assistants) provided peri care for R54. R54's incontinence brief was saturated from front to back with dark urine. V11 removed R54's soiled incontinence brief, place a new brief onto R54, and then proceeded to pull R54's pants up above R54's knees. V11 did not change her gloves or perform hand hygiene when going from touching dirty items to clean. V11 placed a new set of gloves on, wiped a stool smear from R54's buttocks and then pulled R54's pants all the way up. V11 did not change her gloves or perform hand hygiene prior to touching R54's pants. 5. R27's Face Sheet shows she was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, dementia, urinary tract infection, dysuria, delusional disorders, restless legs syndrome, muscle weakness, overactive bladder, and major depressive disorder. R27's Care Plan dated November 22, 2017 shows, Provide toileting assistance as needed. R27's MDS (Minimum Data Set) dated December 16, 2024 shows R27 is not cognitively intact, requires substantial/maximal assistance with toileting, and is dependent on staff for toilet transfers. R27 is occasionally incontinent of bowel and bladder. On January 6, 2025 at 1:17 PM, V10 and V9 (CNAs) transferred R27 onto the toilet. V10 removed R27's soiled with urine incontinence brief and then placed a new clean brief onto R27. V10 wiped R27's peri area and put skin protectant cream onto R27's buttocks. V10 did not removed her gloves nor perform hand hygiene when going from dirty to clean items. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On January 7, 2025 at 11:08 AM, V16 (Infection Control Nurse) said gloves should be changed each time they are soiled. Gloves should be changed when going from dirty to clean items. The facility's Proper Use of Gloves policy revised November 12, 2024 shows, Take gloves off an perform hand hygiene in the following scenarios: When your contact with blood or bodily fluid is complete.