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	02/26/2026

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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify a significant weight loss for a resident (R4), failed to notify a resident's physician, dietician, and power of attorney for a significant weight loss and failed to obtain consistent meal intakes. These failures resulted in R4 experiencing a significant weight loss with no nutritional interventions for 22 days. This applies to 1 of 6 residents reviewed for nutrition in the sample of 28.The findings include:R4's electronic face sheet printed on 2/26/26 showed R1 has diagnoses including but not limited to chronic kidney disease stage 3, urinary tract infection, chronic obstructive pulmonary disease, and Alzheimer's disease.R4's facility assessment dated [DATE] showed R1 has no cognitive impairment and has not experienced weight loss.R4's care plan dated 10/24/25 showed, My health problems may impact my nutritional status .monitor and record food intakes, monitor/record weight. Notify physician and family of significant weight change.On 2/25/26 at 8:57AM, R4 stated, I have had a weight loss since I moved in here a few months ago. I don't think I take any nutritional supplements but I'm not sure.R4's weight record showed on 11/12/2025 R4 weighed 124.4 lbs. On 02/11/26, R4 weighed 114.2lbs which is a -8.2% loss within 3 months.R4's dietician note dated 1/12/26 showed, Notable downward trend in weight since admission with significant weight loss of 5.5% from October to November. Weight has since stabilized, however remains down overall.weight stability desired.Current plan of care remains appropriate as tolerated. Goal for weight and appetite stability.R4's physician's orders dated 1/20/26 showed, Weekly weights x4 weeks to monitor downward weight trend. No weights were documented in R4's medical record for 1/21 or 1/28. The first weight for R4 after the 1/20/26 physician's order was on 2/4/26 (14 days after the order was placed and showed R4's significant weight loss).R4's meal intake logs for January and February 2026 showed R4's meal intakes were not documented/recorded on 29 out of the 57 days.On 2/26/26 at 10:48AM, V12 (Licensed Practical Nurse) stated the CNA's (Certified Nursing Assistants) obtain the weights and will give them to the nurse. We will give them to nursing administration to enter. If there is a significant weight change, we will obtain a reweigh to ensure it is accurate. We will do it the next day or day after so we make sure we get the weight. If it's a true significant weight loss, then we notify the physician and we put a dietary slip in the dietician's box to have her evaluate for interventions. I'm not sure how often the dietician is here. I think maybe once a month. V12 stated, (R4) had a significant weight change but didn't get weighed in January. From December to February she had a significant weight loss. They reweighed and it is still a significant weight loss. February 4th she was 113lbs and reweighed on February 11th and she was 114.2lbs. If a resident is unavailable when their weight is due, then we would try and get it when they return to facility or I leave it open on the orders and tell the next shift to get the weight so we can ensure it is done.On 2/26/26 at10:56AM, V3 (Director of Nursing) stated, CNA's obtain the weights and give them to the nurse's and the nurse is entering them unless there is a discrepancy then they call nursing administration for further direction. If a resident is unavailable for their scheduled weight, then the nurse should enter a one-time order for the weight to be completed the next shift or the next day, whichever is more convenient for the resident. I think the dietician is here monthly, but she also does remote work too. If a significant weight change is noted, the nurses notify the resident's physician (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 0692 Level of Harm - Actual harm Residents Affected - Few	and power of attorney and we document that in a progress notes. We wait for direction from the physician which is usually a referral to dietician and maybe a supplement in the meantime. The dietician will send me reports for weights and any interventions when she does remote work. The last report I got from her was on 2/20/26 and she made no recommendations for (R4). V3 then obtained the weight book for R4's unit and confirmed no weights were written down for R4 on 1/20 or 1/28.On 2/26/26 at 11:39AM, V11 (Registered Dietician) stated, I am in the facility every other week, but I do assessments remotely on a weekly basis. I document a progress note for every resident I perform a review or assessment on. I run a weight change report once or twice a month to check for weight changes. If the staff note a weight change, they will send me a referral by e-mail or put it in my folder at the nurse's station. (R4) is on my list to review today. She lost a significant amount of weight from November to present. She did not have a weight obtained last month which is a problem because she is supposed to be a monthly weight at the very least. She had a weight loss shortly after she was admitted and stabilized and has now had another weight change. I ran my report last week and then again today. I will be recommending a health shake once or twice a day to see how she accepts that. I did not get notified on 2/4 of (R4's) significant weight change. I just pulled the report last week and haven't done my assessments yet. I would say this is a problem that I haven't been notified. I would have requested a reweigh to ensure it was accurate and since it was, I would have implemented a nutritional shake right away to hopefully stabilize or increase her weight.The facility's policy titled, Policy and Procedure for Resident Weights dated 9/22/25 showed, Policy: To monitor weights and weight changes that may indicate a significant weight change in the resident's nutritional status. Significant changes in weight.7.5% gain or loss in 3 months.4. All weights must be documented in the weight book and in (electronic medical record).6. The clinical nurse manager or designee will complete the paperwork (fax) found in the weight book to notify the resident's Doctor/Nurse Practitioner of weight changes.8. Weekly weights will be done as follows.b. any resident with a 5% or greater weight loss or gain over the past month. C. any resident with a physician's order for weekly weights.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to check the temperatures of food before serving and failed to use utensils to stir and remove food. These failures apply to all residents in the facility.The findings include:The CMS Center for Medicare and Medicaid Services form 671 dated 2/24/2026 shows there are 69 residents in the facility.1.On 2/24/2026 at 9:30 AM, V4 (Dietary Manager) said the food for the facility is prepared in the main kitchen and then placed in hot boxes and taken to the kitchenettes on the two nursing units on the second and third floor. V4 said the food temperatures will be taken on the units from the steam table prior to serving the food. At 11:10 AM, V5 (Cook) took the hot boxes containing the noon meal to the second-floor kitchenette. V5 placed all the food for lunch onto the steam table and then checked the temperatures of the regular meat and the pureed meat. V5 documented the temperatures on the log and then proceeded to get serving utensils. When V5 was asked about checking the temperatures of the rest of the food on the steam table, V5 replied, I only need to check the meats, the rest is checked in the kitchen prior to being taken to the kitchenettes. That's how I always do it. At 11:25 AM, V5 delivered the hot box containing the lunch to the third-floor kitchenette. V5 placed the food on the steam table and said she did not have a thermometer to check the temperatures. V4 left the kitchenette to obtain a thermometer for V5. V5 only checked the temperatures of the pureed meat and the regular meat. V4 told V5 she needed to check the temperatures of all the food being served. At 11:42 AM, V4 asked the surveyor to accompany her back to the second-floor kitchenette to make sure the temperatures were taken correctly. In the kitchenette on the second floor, V6 (Prep Cook) and V7 (Cook's Helper) were getting ready to serve the noon meal. V4 told V6 and V7 that the temperatures of the food needed to be checked and documented. V4 said the meat had already been checked. V6 grabbed a thermometer and attempted to take the temperatures; however, the thermometer was not reading the temperature adequately. V4 again had to leave to obtain a new thermometer. V6 then checked the temperatures of the food and would look at V4 for confirmation it was okay. V6 needed to be told repeatedly that all the food needed to be checked for the proper temperature. The temperature for the pureed vegetable was 101 degrees Fahrenheit (F) and V4 told V6 she needed to reheat the food and check the temperature again. V6 placed the pan of pureed vegetables in the steamer to reheat. As V6 was observed checking the temperature of the pureed vegetables several times, V4 could be heard telling V6 it needed more time in the steamer. On 2/24/2026 at 12:15 PM, V6 said the temperatures of the food on the steam table needed to be at 165 degrees F.On 2/24/2026 at 12:15 PM, V7 said the temperature of the food on the steam table needed to be at least 150 degrees F.On 2/24/2026 at 12:45 PM, V4 said all food needs to have the temperature checked before serving to ensure the food is at 140 degrees F for the safety of the residents to prevent a food borne illness.The Food Temperature Monitor Sheets dated 2/24/2026 shows the temperature of the hot cereal and regular egg for breakfast and the regular meat and the pureed meat were the only food temperatures being taken. On the menu for 2/24/2026 for breakfast the food served was cream of wheat or cold cereal, fried egg, ham and hashbrowns. The noon meal for 2/24/2026 was French dip with au jus, French fries and succotash.The Food Temperature Monitor Sheets for February 1 to February 23, 2026, shows multiple meals where the temperature was not documented as taken prior to serving the meals.The undated Cooking Foods-Internal Temperatures policy shows the appropriate food service staff will be trained on how to use a thermometer. The undated policy for Food Temperatures-Cooked Foods shows the major cause of food borne illness are improper cooking, cooling, reheating and holding temperatures. Hold all hot foods at 135 degrees F and check temperatures frequently.2. On 2/25/2026 at 9:57 AM, V8 (Cook) was preparing the mechanical soft foods and the pureed foods. V8 placed the meat in the blender and pulsed to a ground consistency, then scooped out the meat with a gloved hand. V8 then placed the next piece of meat into the blender and broke apart the meat with the same gloved hand. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	V8 then sprayed the pan and grabbed the lid to the blender with the same gloved hand and then V8 pulsed the meat and then using the same gloved hand, scooped out the meat. V15 (Dietary Supervisor) then grabbed a spatula and handed it to V8 to use. V8 made all the portions of meat and then did the vegetables, added it all into a bowl and mixed and scooped out the portions and wiped off the spoon with gloved hands he had just used to arrange the pans. V15 said utensils must be used to move food from one place to another to prevent cross contamination.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure an indwelling catheter was secured and failed to ensure catheter tubing was kept off the floor for 1 of 2 residents (R11) reviewed for indwelling catheters in the sample of 28. The findings include:On 2/24/26 at 11:49 AM, R11 was seated in his wheelchair in the dining room. R11's indwelling catheter drainage bag was under his wheelchair in a privacy bag. R11's catheter tubing was looped under the chair and touching the floor. R11 finished eating lunch at 12:39 PM and self-propelled his wheelchair from the dining room table to the nurses' station. R11's catheter tubing continued to drag on the floor. R11 self-propelled to V9 (Registered Nurse) at the nurses' station and obtained a chocolate wafer bar. R11 sat in the common area talking with another Certified Nursing Assistant (CNA) regarding his shower. R11 said he needed to use the bathroom first. V9 placed the foot pedals on R11's wheelchair and pushed him toward his room. R11's catheter tubing continued to drag on the floor. V10 (CNA) said the shower was ready for him. R11 said he needed to go to the bathroom. V10 donned a gown and gloves and pushed R11's wheelchair into his bathroom. R11's catheter tubing continued to drag on the floor. V10 assisted R11 to stand from the wheelchair and pivot transfer to the toilet. V10 pulled R11 pants down and he sat on the toilet. R11 did not have a catheter secure device in place. V10's catheter tubing was hanging freely. After R11 finished using the bathroom, V10 assisted him back to the wheelchair. R11's catheter tubing was touching the floor when he propelled to the sink to wash his hands. As R11 self-propelled his wheelchair out of the bathroom, he stepped on his catheter tubing with his right foot, then his left foot. R11 exited the bathroom and waited for V10. R11's catheter tubing was under his right foot. V10 exited the bathroom and R11 began self-propelling forward. R11's catheter tubing went under his left foot, then drug on the floor as V10 pushed R11 to the shower room. R11's Physician Order Report dated 1/26/26-2/26/26 showed R11 had diagnoses to include, but no limited to Alzheimer's Disease, history of urinary tract infections (UTIs), weakness, polyosteoarthritis, retention of urine, and benign prostatic hypertrophy (enlarged prostate). This document showed R11 had an indwelling catheter. R11's Care Plan initiated 4/28/25 showed he had an indwelling catheter related to urinary retention. This care plan showed an intervention to use a catheter strap (catheter secure device). R11's facility assessment dated [DATE] showed he had severe cognitive impairment and had an indwelling urinary catheter. On 2/26/26 at 8:54 AM, V3 (Director of Nursing - DON) said R11's catheter tubing should not be dragging on the floor for infection control purposes. V3 said the catheter tubing and/or drainage bag should not touch the floor due to the risk of cross-contamination. V3 said the facility staff should ensure any resident with an indwelling catheter had a secure device in place. V3 said the purpose of the catheter secure device was to keep the catheter positioned properly and prevent irritation. V3 said if a resident steps on the tubing it could cause an obstruction, or the catheter could come out. The facility's Urinary and Suprapubic Catheter Management Policy revised 9/6/24 showed, Purpose: Establish the routine care administered when an indwelling catheter is in place. This routine care protects the resident from infection, injury, and promotes comfort.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure hot food was served at palatable temperatures for 3 of 3 residents (R3, R54, & R60) reviewed for dining in the sample of 28.The findings include:On 2/24/2026 at 9:49 AM, R3 was sitting in her recliner in her room. R3 stated she had some concerns about the hot food being served cold. R3 stated she eats in the dining room and by the time her food gets to her it is cold. R3 stated residents have brought it up at the Resident Council meetings.On 2/24/2026 at 12:14 PM, R3 was served her lunch meal of roast beef on a bun, au jus, fries, and cooked carrots. R3 stated her food was cold. R3 stated she is tired of food coming out cold. R54 was served her lunch and stated her fries and carrots were cold. At 12:57 PM, R60 stated her food was served cold.The Resident Council Meeting Minutes dated November 20, 2025, showed dietary concerns that included residents wanted more efficient ordering, so food is not cold. A resident suggested that staff wait and serve 4-6 tables at a time, so everyone's food is hot, and they all get it at the same time.The Resident Council Meeting Minutes dated January 22, 2026, showed residents mentioned that vegetables are always cold. Residents stated that the dinner meal on 1/22/26 was also cold. Residents wondered where the temperatures were being taken for the food: on the surface or deep in the pan. On 2/26/26 at 8:58 AM, V15 Dietary Supervisor stated the food is prepared in the main kitchen and the temperature is checked before it leaves the kitchen and is taken to the health center. The food is put on the steam table in the health center, and the temperatures are checked again. V15 stated it was important for food temperatures to be what they should be such as hot foods served hot for good food quality. V15 stated it was also important, so the food is enjoyable and palatable. The Minimum Data Set (MDS) dated [DATE] for R3 showed no memory problems or cognitive impairment. The MDS dated [DATE] for R54 showed no memory problems or cognitive impairment. The MDS dated [DATE] for R60 showed no memory problems or cognitive impairment.The facility's Resident Meal Service policy (2009) showed Residents will be provided with nourishing, palatable, attractive meals that meet daily nutritional and special dietary needs. The dining experience will enhance the resident's quality of life by supporting their individual dining needs. Food items and plating will be consistent with the residents' needs. The food service manager will perform meal rounds routinely to determine if meals are attractive and nutritious and meet the needs of the individual. The food service manager will observe meals for preferences, portion sizes, temperature, flavor, variety and meal passes for accuracy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to wear personal protective equipment (PPE) in a manner to prevent the spread of COVID-19. This applies to 1 of 2 (R19) residents reviewed for isolation precautions in the sample of 28.The findings include:R19's electronic face sheet printed on 2/25/26 showed R19 has diagnoses including but not limited to Alzheimer's disease, diarrhea, rash, and vascular dementia.R19's nursing progress notes dated 2/16/26 showed R19 tested positive for COVID-19 and was placed on contact, droplet, and airborne precautions.On 2/24/26 at 9:47AM, R19's door had a sign posted showing, Contact, droplet, airborne precautions.On 2/24/26 at 12:24PM, V13 (Certified Nursing Assistant-CNA) applied a gown, gloves, shoe covers, and an N95 mask over her surgical mask and entered R19's COVID positive room.On 2/25/26 at 8:53AM, V14 (CNA) came out of R19's room with a surgical mask underneath her N95 mask. V14 stated, I just wear a surgical mask under my N95 mask because I already had a surgical mask on so it doesn't make sense to take it off to put an N95 mask on. (R19) is on isolation because he has COVID.On 2/26/26 at 11:09AM, V3 (Director of Nursing) stated, PPE for COVID isolation should be a gown, N95 mask, goggles/face shield, and gloves. A Surgical mask shouldn't be worn underneath the N95 because it does not create a seal for the N95 to be worn correctly and puts staff at risk for contracting COVID.The facility's policy titled, (Facility) mask policy) dated 1/23/23 showed, Masks and face covering are intended to limit the risk of the wearer exposing a coworker or resident to undetected illnesses or infection, including COVID-19.The Centers for Disease Control document titled, How to Use your N95 Respirator dated 3/2/25 showed, Your N95 respirator must form a seal to your face to work properly. Your breath must pass through the N95 respirator and not around its edges. Jewelry, glasses, and facial hair can cause gaps between your face and the edge of the respirator. The N95 respirator works better if you are clean shaven. Gaps can also occur if your N95 respirator is too big, too small, or it was not put on correctly.