STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003024	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRHAVEN CHRISTIAN RET CENTER	3470 NORTH ALPINE ROAD ROCKFORD, IL 61114

(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
S 000	Initial Comments Investigation of Facility Reported Incident of 3/20/24/ IL171224	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003024	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRHAVEN CHRISTIAN RET CENTER	3470 NORTH ALPINE ROAD ROCKFORD, IL 61114

(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
S9999	Continued From page 1	S9999		

resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These requirements were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure a safe transfer was provided for 1 of 3 residents (R1) reviewed for risk for falls on the sample list of 3. This failure resulted in R1 sustaining a clavicle fracture during a stand lift transfer on 3/20/24.

The findings include:

The Nurse's Note dated 3/20/24 for R1 showed, called to room by CNAs (Certified Nursing Assistant) at 3:10 PM. CNAs stated R1 was transferring from toilet to wheelchair when she became weak and had to be lowered to floor by CNAs. R1 sitting on floor between toilet and wheelchair with her legs under her. R1 was holding onto the wheelchair and resting her head against door frame. Staff were able to lift R1 off

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003024	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRHAVEN CHRISTIAN RET CENTER	3470 NORTH ALPINE ROAD ROCKFORD, IL 61114

(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
S9999	Continued From page 2	S9999		

floor, onto toilet, then transfer her into wheelchair, and lifted into bed. Had a bowel movement while in toilet. Vital signs: (temperature) 98.0, (heart rate) 100, (respiratory rate) 20, and (blood pressure) 158/90. Oxygen saturation 90% on room air. Range of motion x 4 extremities without pain. Denies any pain or complaint. Beginning of a bruise becoming visible to right inner leg below knee. No other injuries seen. R1 changed by CNAs and assisted to wheelchair. R1 ambulating in wheelchair per her normal behavior. Called to (R1's) room by CNAs a second time at 7:50 PM. R1 passed out on toilet during HS (bedtime) care. Vital signs: (temperature) 98.1, (pulse) 110, (respiratory rate) 26, (blood pressure) 112/82. Started responding after several minutes but remained lethargic. R1 was hooked to the stand lift while on the toilet as precaution after falling earlier while in bathroom. R1 was not able to assist staff with transfer off toilet. Stand lift used to pull R1 far enough forward to get a wheelchair behind her but this nurse had to pull on her arms to keep her from falling through the stand lift. Transferred R1 into the wheelchair and then lifted her into bed. R1 complained of left arm pain after transfer. Contacted daughter/POA (power of attorney) 8:05 PM and informed her of her mother becoming unresponsive while on toilet during HS (bedtime) care. Also informed of difficulty transferring mother into wheelchair and then to bed and mother complained of left arm pain after transfer. Inquired if she wanted R1 sent to hospital. Stated to send mother to hospital for evaluation. R1 remains lethargic but responds to questions. Denies any pain at rest but complains of left shoulder pain with movement. No pain when shoulder gently palpated. New bruise noted next to old bruise on left arm above left wrist. Ambulance arrived at 8:55 PM. R1 out to the emergency room at 9:00 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003024	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRHAVEN CHRISTIAN RET CENTER	3470 NORTH ALPINE ROAD ROCKFORD, IL 61114

(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
S9999	Continued From page 3	S9999		

The facility Resident Accident/Incident Report dated 3/22/24 for R1 showed, resident became unresponsive while on the toilet. After a few minutes the resident started to become responsive but lethargic. Staff attempted a stand lift transfer but was unable to complete safely. Staff assisted the resident to the wheelchair then to bed. R1 complained of arm pain.

The hospital Inpatient Progress Note dated 3/22/24 for R1 showed she had sepsis due to acute cystitis, left clavicular midshaft fracture, acute metabolic encephalopathy with underlying history of dementia, acute kidney injury, and hypertension.

The Nurse's Note dated 3/25/24 for R1 showed, R1 returned from the hospital with a diagnosis of sepsis and left clavicle fracture. R1 was tired with confusion noted. R1 had a sling to her left arm; she complained of left shoulder and leg pain with any movement. The staff nurse spoke with V2 DON (Director of Nursing) who stated to make R1 a full mechanical lift transfer until she was evaluated by the rehabilitation nurse.

The Restorative Nurse Assessment dated 3/26/24 for R1 showed R1 is to be transferred with a full mechanical lift and two staff due to her fractured left clavicle and being non-weight bearing to her left arm.

On 3/27/24 at 9:15 AM, V2 DON (Director of Nursing) stated, R1 had two incidents on 3/20/24. The first incident the CNA was getting R1 off the toilet. R1 was a standby assist at that time. The CNA lowered R1 to the floor. The CNA said R1 was going down so she lowered R1 to the floor. The second incident was after supper; R1 needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003024	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRHAVEN CHRISTIAN RET CENTER	3470 NORTH ALPINE ROAD ROCKFORD, IL 61114

(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
S9999	Continued From page 4	S9999		

to use the bathroom. R1 became lethargic and they got the stand lift. It sounded like R1 was able to stand at the beginning of the transfer but during the transfer she couldn't complete it. V7 LPN (Licensed Practical Nurse) was trying to hold R1 up on the stand lift and get her to her wheelchair. The safest way to transfer R1 would have been using the full mechanical lift. When V7 was trying to hold R1 up in the stand lift, I think that is when her clavicle was fractured. I think I would have put a gait belt on R1 and lowered her to the floor and then transferred R1 with a full mechanical lift. It would have been hard to get the full mechanical lift in there, but they could have moved her out a little and then lifted R1 with the full mechanical lift.

On 3/27/24 at 11:52 PM, V3 CNA stated, if a resident is not responding appropriately, she would let the nurse know first. V3 stated the stand lift machines are for residents that can bear some type of weight and it would be unsafe to use one if the resident wasn't able to bear weight.

On 3/27/24 at 11:59 AM, V5 CNA was in R1's room. R1 was asleep on her right side in bed. R1's bed was low to the floor with a mat on one side of the bed. R1 had a clip alarm in place. V5 stated the care plan above the resident's bed tells staff how a resident transfers. V5 stated R1 has not gotten out of bed since she came back from the hospital. The care plan on the wall above R1's bed dated 1/18/24 showed she transfers with 1 assist, has no special aides, and uses a wheelchair for mobility.

On 3/27/24 at 1:20 PM, V6 APN (Advanced Nurse Practitioner) stated that she would have to agree with V2 and using the stand lift if R1 wasn't able to bear weight or was unresponsive or her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003024	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRHAVEN CHRISTIAN RET CENTER	3470 NORTH ALPINE ROAD ROCKFORD, IL 61114

(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
S9999	Continued From page 5	S9999		

vitals were off would not be the way to transfer R1. V6 stated she agreed with V2 stating that R1 should have been lowered to the floor and then the full mechanical lift used for the resident's safety. V6 stated the resident needed to be able to bear weight and know what to do in order to use the stand lift.

On 3/27/24 at 1:39 PM, V7 LPN (Licensed Practical Nurse) stated, R1 was unresponsive on the toilet and sitting awkward on the toilet. V7 stated he did R1's vital signs. R1 started to respond but was not herself. R1 was already in the stand lift. V7 stated they decided to use the stand lift to transfer R1 even though she could not stand. V7 stated he held R1's arms up and out while he was facing the resident. V7 stated he was trying to hold R1 up or she would have fallen through the sling and crumbled. V7 stated the stand lift was pulled out of the bathroom to the doorway and R1 was transferred to her wheelchair. V7 stated R1 complained of pain after that. V7 stated 4 staff lifted R1 from her wheelchair to her bed.

On 3/27/24 at 2:04 PM, V8 CNA stated, when she got R1 up the first time to use the bathroom R1 was struggling a little bit and is usually a standby assist for transfers. V8 stated she got R1 to the toilet, cleaned her up, and stood her up. V8 stated when she went to transfer R1 to the wheelchair, R1's knees buckled so she lowered the resident to the floor. V8 stated she yelled for help. V9 CNA, V7 LPN and I picked R1 up with a gait belt, sat her on the toilet, brought the stand lift in and used it to transfer R1 to her wheelchair. V8 stated after supper she took R1 to the bathroom using the stand lift and R1 did not want to hold onto the stand lift when V8 was putting her on the toilet. V8 stated when she tried to get R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003024	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRHAVEN CHRISTIAN RET CENTER	3470 NORTH ALPINE ROAD ROCKFORD, IL 61114

(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
S9999	Continued From page 6	S9999		

off the toilet, R1 wouldn't hold on and almost went to the ground. V8 stated she had to put R1 on the toilet and call the nurse. V8 stated V7 LPN came in, they lifted R1 up using the stand lift with V7 holding R1 under her arms; R1 was not bearing weight. V8 stated they got R1 out of the bathroom, lifted her a little bit and put her in the wheelchair. V8 stated to use the stand lift the resident needs to be able to bear weight and hold on so they don't fall. V8 stated R1 couldn't hold on. V8 stated I guess we should have used the full mechanical lift.

The Fall Risk form dated 1/17/24 for R1 showed a score of 17; a score of 10 or greater is high risk for falls.

The facility's Safe Handling and Limited Lift/Movement Policy (6/12/23) showed, Purpose: To determine safe handling and transferring of residents in a manner that recognizes safety for all residents and staff. Policy: Mechanical lifting equipment and/or other approved resident handling aids will be used to prevent manual lifting of residents except when absolutely necessary, such as in a medical emergency or building emergency (such as fire). If a resident can stand for 4 seconds or less, while bearing weight, with assistance and is cooperative, and able to sit with no support - use a stand lift. If a resident is non-weight bearing or unable to assist with a transfer - use a full mechanical lift. If a resident has fallen on the ground and is unable to get up on their own, use a full mechanical lift to recover them from the ground. Two staff persons must be present for all mechanical aided transfers, including stand lift and full mechanical lift.

(B)