(X6) DATE

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	
		IL6003024	B. WING		02/1	5/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
FAIRHAVEN CHRISTIAN RET CENTER  3470 NORTH ROCKFORD						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Annual Licensure S	Survey				
S9999	Final Observations		S9999			
	Statement of Licensure Violations					
	300.661					
	Section 300.661 He Check	ealth Care Worker Background				
	Worker Background	oly with the Health Care d Check Act and the Health ground Check Code.				
	This requirement was not met as evidenced by:					
	failed to perform ba	and record review, the facility ackground checks for 1 of 10 d for background checks in				
	This failure had the residents.	potential to affect all 70 facility				
	The findings include	e:				
		ation for Medicare and 3/24 showed 70 residents in				
	Director said V8 ho we weren't doing st at that time. We do police check in her	43 PM, V7 Human Resource usekeeper started in 2005 and ate police background checks n't have an original state file. I cannot produce the 2005 did not retroactively				

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 03/05/24

TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6003024	B. WING		02/1	5/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•		
FAIRHAVEN CHRISTIAN RET CENTER 3470 NORT ROCKFORD							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DULD BE COMPLETE		
	hired before it was a background checks starting work to know vulnerable residents with a disqualifying residents. Resident be at risk if the screen on 2/15/24 at 9:00 (DON) said it's importance on employe anyone here with a the residents. Abusconcerns would be were not done. Screen decrease the lift and is important to and residents.  V8 housekeeping's application showed position. The facility's House showed cleans and public areas and du of support services departments as assiste main building (Loccasionally outsided duplexes.  The facility's 2017 Fand Exploitation Pothe resident has the neglect, misappropriand exploitation as provide these prote	kground check employees required. It's important to do to on employees prior to them to their status. We have shere. We can't have anyone criminal record exposed to the staff and facility safety would be reining was not done.  AM, V3 Director of Nursing cortant to do background es because we don't want criminal offense working with e, domestic, and theft a potential issue if checks beening potential employees celiness of abuse of residents protect us all-staff, the facility  5/3/05 employment application for a housekeeper keeper Job Description organizes resident rooms, uplexes. Works in other areas	S9999	DEFICIENC!)			

Illinois Department of Public Health

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					TE SURVEY MPLETED			
		IL6003024	B. WING		02/1	5/2024		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3470 NORTH ALPINE ROAD  ROCKFORD, IL 61114								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
\$9999	of residents, and m property. These wri are not limited to, th Screening. To ensu within its control to these policies must the policies and proeffective. The object comply with the seven and neglect detection policy of this facility volunteers prior to a Screening componer.	isappropriation of resident tten policies must include, but he following components: re the facility is doing all that is prevent such occurrences, be implemented, otherwise, be implemented, otherwise, be implemented not be stive of the abuse policy is to ren-step approach to abuse on and prevention. It is the to screen employees and working with residents. The pents include verification of license	S9999					

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Illinois Department of Public Health STATE FORM

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