STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Oaks Rehab & Healthcare	1515 Blackhawk Boulevard South Beloit, IL 61080

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490 Based on interview and record review, the facility failed to immediately provide cardiopulmonary resuscitation (CPR) to a resident (R9) found not breathing and pulseless whose physician's order showed the resident was a Full Code. This failure led to a delay in R9 receiving CPR and R9 dying in the facility. This applies to 1 of 3 residents (R9) reviewed for death in the sample of 14. This failure resulted in an Immediate Jeopardy. The Immediate Jeopardy began on [DATE] at 5:40 PM, when facility staff failed to immediately initiate CPR on R9 when she was found unresponsive and pulseless. This failure resulted in R9 receiving CPR 42 minutes after being found unresponsive and pulseless, which resulted in R9 dying in the facility on [DATE]. V1 (Administrator) was notified of the Immediate Jeopardy on [DATE] at 10:13 AM. The surveyor confirmed by interview and record review that the Immediate Jeopardy was removed, and the deficient practice corrected, on [DATE], prior to the start of the survey and was therefore Past Noncompliance. The findings include: R9's Physician's Order Sheet shows an order dated [DATE] for Full Code. R9's Care Plan, dated [DATE], shows, [R9] does not have a completed POLST (Physician Orders for Life-Sustaining Treatment). She is a FULL CODE .Ensure resident's wishes are honored in regard to any advanced directive. R9's Health Status Note, dated [DATE] at 11:29, PM shows, 1740 Today this writer went into patients room to check on resident get her blood sugar and offer her medication, patient was cold to touch body limp checked patients vitals no bp (blood pressure), no pulse, no respiration, had [V25] also check vitals. Patient had mottling on left side of body. Patient was laying on left side. per CNA (Certified Nursing Assistant) patient was checked at 3 pm MOD (Manager on Duty) called at 1745 DON (Director of Nursing) called at 1746. Called POA (Power of Attorney)? .1750 Notified #2 emergency contact. Called 911 report given arrived at 1815 patient assessed for any vitals started CPR and did CPR for 20 minutes patient was asystole the whole time. 1835 coroner was called (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

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Fair Oaks Rehab & Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1515 Blackhawk Boulevard South Beloit, IL 61080	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:25 AM, V22, Registered Nurse (RN) said she went into R9's room at 5:40 PM, and she had no respirations, no pulse, and no blood pressure, and was mottled from her chest onto her left side. V22 said she checked a temperature and it was around 96 degrees Fahrenheit. V22 said she did not know the policy for finding someone passed away, so she called V2 (Director of Nursing). V22 said she did not know if R9 was a full code or DNR (Do Not Resuscitate). but found out she was a full code about ,d+[DATE] minutes after leaving her room when she looked in the computer. V22 said a resident's code status can be found on the computer or on the crash cart. V22 said it took her a long time to figure out if she was a full code because she got another nurse to verify that she did not have any vitals and was trying to get the CNA in there to help her. V22 said after the other nurse came in and verified she did not have any vitals, she called V24 (Manager On Duty) and told her R9 had expired. V22 said she does not remember what V24 had told her, but she then called V2 (DON) and V2 told her to start CPR. V22 stated, [V2] told me to start CPR but I didn't, because she was mottled and draining fluids from her mouth, so I did not do it. It was right after supper time and I didn't have any help at that time. V22 said after speaking to V2, she called 911 and went down to R9's room and about a minute later, 911 arrived and started CPR. V22 said she should have started CPR immediately because she was a full code. On [DATE] at 12:47 PM, V23 (CNA) said around 3:00 PM, R9 was laying in bed on her left side and appeared to be sleeping. V23 said around dinner time, V22 came out of R9's room and said she had passed away and she needed to clean her up. V23 said she went to the dining room and spoke with the other CNAs, and told them R9 had passed away. V23 said she then went back into the room and after about 10 minutes, V22 came in and told her she needed to clean her up. V23 said she proceeded to provide incontinence care to R9. V23 said R9 had a little bluish color under both of her breasts and the left side of her head (where you would lay your head on a pillow) that was light blue and it was the size of a half of a hand. V23 said she was able to see all of R9's body when she cleaned her up, and she did not have any other discolorations seen on her body. V23 said after she was done cleaning R9 up, the parametics arrived and started CPR. On [DATE] at 9:30 AM, V25 (RN) said she was at her medication cart right before supper on [DATE] when V22 came walking down the hall and said, I think my patient died . V25 asked V22 if she wanted her to verify, and she said yes, so they walked down to R9's room and she listened for an apical pulse for one minute and listened for respirations and there was none. V25 said R9's face was pale and her lips were normal color. V25 said R9 had a gown and blankets on, so she was unable to see her full body. V25 said she then told V22, Yes, she has passed on. V25 said her and V22 then walked down the hallway and she went to her medication cart, and V22 went to sit at the nurse's station computer, which is about 5 feet from her cart. V25 said she heard V22 say, Oh my God, this patient is a full code. I am going to call [V2]. V25 said she heard V22 on the phone with someone and she hung up the phone and said, [V2] wants me to code her. V25 said she responded with ok, and then V22 responded with, I am not doing CPR, I am calling 911. V25 said a code was never called and no compressions were ever started by her or V22. V25 said, It was [V22's] patient and she was pretty strict about not doing CPR, so I did not do anything. V25 said that a code blue should have been called and CPR started. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:19 AM, V24 (MOD) said she received a call from V22 at 5:47 PM on [DATE]. V24 said V22 said her resident had passed away. V24 said she responded with, I'm sorry, was she hospice? V24 said V22 responded with, No, she was a full code. V24 said she immediately told her to get off the phone and initiated compressions and have someone call 911. V24 said V22 responded with, No, she is already mottled and dead, I'm calling [V2]. V24 said she then told her again she needs to immediately start compressions, and V22 hung up the phone on her. V24 said there is no reason that anyone should not do CPR on a resident if they are a full code. V24 said CPR should be initiated right away. On [DATE] at 11:51 AM, V2 (DON) said V22 called her at 5:49 PM on [DATE] and said R9 had passed away and started telling her who she had called (on call phone and POA). V2 said she asked V22 what R9's code status was and she said, Let me check. V2 said V22 responded that R9 was a full code. V2 said she told her that she should have started CPR right away, and needed to start a code. V2 said said ok and hung up the phone. V2 said she called the facility back after notifying the Administrator and corporate nurse about what was happening, and V22 answered the phone. V2 said she asked her if she started a code and she said, no. V2 said she again told her she needs to start CPR and call 911 and V22 responded with, She's gone, it looks like she has been gone for a little while. V2 said even if R9 had mottling to her left side, V22 still should have started CPR immediately and continued CPR until the paramedics arrived. V2 said if a resident is found unresponsive with no pulse or respirations, the staff should immediately check their code status in the medical record or on the crash cart and start CPR right away if they are a full code. On [DATE] at 2:33 PM, V8 (Nurse Practitioner) said she was surprised to hear R9 had passed away because she had just seen R9 a few days prior and she was doing ok. V8 said she would expect that if a staff member found a resident unresponsive with no pulse and respirations, they should immediately check their code status and if they are a full code, immediately start resuscitation efforts. V8 said she is not aware of any situations were a nurse would not perform CPR if a resident is a full code. V8 said they should initiate CPR immediately and continue until a physician/provider or EMS (Emergency Management Services) are at the bedside. V8 said mottling in a resident does not always mean that they are deceased . V8 said a resident can have mottling for various reasons including hypoxia, change in heart rhythm, or change in vitals. V8 said a code is still warranted even if the resident has mottling present. On [DATE] at 12:33 PM, V27 (Local Fire Department-Deputy Chief) said he responded to the call on [DATE]. V27 said thatwhen they arrived, they asked if R9 was a DNR or full code, in which the nurse responded she was a full code. V27 said they immediately initiated CPR. V27 said R9's face was pale, lips were pink and her core and arms were still warm to touch. V27 said the facility staff were not doing CPR upon their arrival. The Local Fire Department Narrative, dated [DATE], shows, Staff stated patient was last seen at 17:40, and at that time, the staff noted that the patient was not breathing and was possibly deceased and called 911 at 18:06, [First Crew Members to arrive at the scene] stated to [Second Crew Members to arrive at the scene] that no one was performing CPR upon their arrival and that their CPR was the first CPR initiated at approximately 18:22. [Crew Member] asked the staff if the patient had a valid DNR, to which the staff stated no, the patient was a full code, and they were not aware that she was a full code. V22's CPR Certification Card shows she was certified in performing CPR on [DATE] and expired ,d+[DATE]. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's Cardiopulmonary Resuscitation Policy, dated ,d+[DATE], shows, The goal of early delivery of CPR is to try and maintain life until the emergency medical response team arrives to deliver Advanced Life Support (ALS). If a resident is found unresponsive and not breathing normally, a clinical staff member will verify code status using the medical records. If the resident is full code, per the medical record, a staff member that is certified in CPR will initiate CPR. The facility presented an abatement plan to remove the immediacy on [DATE]. The survey team reviewed the abatement plan and accepted the abatement plan on [DATE]. The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility: 1. On [DATE], the Director of Nursing, Assistant Director of Nursing, Post Acute Nurse, MDS Nurses, Wound Care Nurse, Regional Director of Nursing, Charge Nurse or Designee educated clinical staff regarding the CPR policy and procedure and Advanced Directive policy and procedure including identification of when CPR is needed. All additional staff will be educated prior to working their next scheduled shift and new hires will be educated during the orientation process. 2. On [DATE], current resident orders were reviewed by the regional nurse to confirm resident preferences aligned with code status. 3. On [DATE], the facility nurse management team started auditing certified and licensed nursing staff on appropriate action if a resident is found unresponsive with no pulse or blood pressure and not breathing. This will be done four times a week for six weeks. A mock code was conducted on [DATE] and [DATE] on all three shifts to ensure understanding of the CPR policy and procedure. The Director of Nursing or designee will conduct a mock code with clinical staff once per month for 6 weeks to verify understanding of CPR policy and procedure, including identification of when CPR is needed. Any noted issues will be addressed and will be discussed during the QAPI (Quality Assurance and Performance Improvement) process. 4. On [DATE], an emergency QAPI meeting with the QAPI team members and Medical Director was held to discuss the deficient practice and review the policies. The CPR policy was reviewed, and no changes were needed to the current policy. The Advance Directive policy was reviewed, and no changes were needed to the current policy.

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F 0684

Level of Harm - Actual harm

Residents Affected - Few

Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 34117

Based on interview and record review, the facility failed to assess and monitor a change of condition for a resident following surgical repair of left humerus fracture. This failure resulted in R1 sustaining a new fracture to her left distal humerus shaft discovered on her outpatient appointment on 1/29/25 (nine days after admission) and requiring new surgical intervention. This applies to 1 of 3 (R1) residents reviewed for quality of care in the sample of 14.

The findings include:

R1's face sheet shows she is an [AGE] year old female admitted to the facility on [DATE], with diagnoses included unspecified fracture of shaft of humerus left arm, orthopedic aftercare, cognitive communication deficit, aphasia, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and primary osteoarthritis.

R1's Final Incident Report, dated 1/31/25, documents (R1) was admitted on [DATE], post fall with left humerus fracture status post nailing on 1/14/25. R1 had an ortho follow up appointment on 1/30/25. Facility received a phone call that R1 had a fracture to her distal humeral shaft that had been missed during her hospital stay and that would require surgery V19 (R1's Orthopedic Surgeon) stated the fracture was new and was a torsional injury .

On 2/10/25 at 4:45 PM, V19 said absolutely not R1's fractures was not missed during her hospital stay. On 1/20/25, R1's dressing was changed at the hospital with an ace (elastic) bandage in place. R1 was able to move her left arm as a unit. R1 was discharged to the facility with weight bearing as tolerated. At her post op appointment on 1/29/25, R1's left arm was in a sling, and she was not able to move her left arm with increased swelling. R1 did not have an order for a sling, and was not wearing a sling when she was discharged from the hospital. An X-ray was done and showed a new spiral fracture to the left distal humerus. This was a torsional injury caused by twisting movement, pressure, force, and rotation. The facility did not report any changes regarding R1. He would expect the staff to assess the post-surgical extremity every shift, monitor for swelling, edema and change in range of motion. Staff should call and obtain an order for the use of sling.

On 2/10/25 at 11:36 AM, V16 (Occupational Therapist) said she did R1's evaluation for OT on admission. R1 did not come with a sling. She placed the sling on R1's left arm and removed the ace bandage because R1 was having a hard time keeping her arm positioned and placed the sling on for comfort. Nursing usually gets the order for the use of a sling, it was for protection. The next time she saw R1 was on 1/25/25, R1 was lying in bed with her left arm behind her and in significant pain, she would cry out with movement. She said she reported to nursing regarding her pain.

On 2/10/25 at 10:17 AM, V17 (COTA-Certified Occupational Therapist Assistant) said she was working with R1 the next three days after her evaluation. On 1/21/25, R1 had no pain, her left arm was in a sling for positioning and edema. On 1/23/25 she noticed increased pain and edema to her left arm. She could only use her left hand and she did not do therapy with her left elbow or shoulder, she did not attempt therapy because of the increased pain. She stated she reported the pain to nursing.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 2/10/25 at 8:44 AM, V13 (Physical Therapist) said normally if a resident has a sling it comes with them on admission and should have orders for the use of a sling. On 2/6/25 at 11:19 AM, V14 (PTA-Physical Therapy Assistant) said during physical therapy, the sling was in place because R1 would attempt to use her left hand for pulling. R1 was able to use the walker one time with her left arm resting on walker. She said R1 was non-weight bearing to her left arm and she did not want her to use her arm to push off. The sling was used for safety, when she did not have the sling on her arm was externally rotated and in downward hanging position. She never did any exercises with her elbow, and reported to nursing R1 would act out in pain and had increased swelling to her left arm. On 2/6/25 at 2:17 PM, V21 (Registered Nurse/RN) said R1 was alert to self, dependent on staff for cares. R1 did not complain of pain. R1's left arm had no edema and had a sling in place. When she received report, they told me she had a sling. There should be a physician's order for a sling. Staff should assess the surgical extremity site every shift. She does not recall therapy reporting R1 having increased pain or swelling. On 2/6/25 at 2:37 PM, V18 (RN) said she was R1's nurse on 1/23/25 and the day she went out for her follow up appointment on 1/29/24. She reported R1 had no pain or swelling to her left arm. R1 had a sling on with gray tape, she never saw her arm out of sling. Usually there is an order for the use of a sling. She did not know there was no order for a sling. The surgical extremity should be assessed every shift and monitored for swelling and pain. She does not recall therapy reporting R1 having increase pain or swelling. On 2/10/25 at 2:15 PM, V30 (Certified Nursing Assistant-CNA) said R1 did have not have the will to get up and do anything, her left arm was tender to the touch and sore. She was not motivated to get up. Her left arm was in a sling and was one person transfer. She could not communicate her needs. On 2/10/25 at 2:46 PM, V29 (RN) said she does not recall R1 or if therapy staff reported R1 having increased pain and edema. Assessments should be done every shift, and any changes of condition should be reported. On 2/10/25 at 12:07 PM, V2 (Director of Nursing/DON) said she is not sure how R1 sustained a new spiral fracture while at the facility. They were notified about R1's fracture during her outpatient appointment. The staff reported it was a fracture they missed. She followed up with V19, and he confirmed it was a new fracture caused by a twisting force. R1 was admitted to the facility on [DATE], there was no physician order to use a sling. Nursing should do a daily assessment of the extremity site and report any changes. She would expect staff to identify a change in the resident's extremity and notify the physician. Nursing is responsible for entering the physician orders and verifying all orders are carried out. R1's Xray report, dated 1/15/25, documents left humerus xray unremarkable appearance of open reduction internal fixation hardware. Anatomic post fixation fracture alignment. No unexpected postprocedural finding. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R1's Ortho Discharge Summary report, dated 1/20/25, document left humerus closed reduction with insertion of humeral nail on 1/14/25 .left upper extremity skin warm and dry, left hand edema improving. Left arm elevated on pillow .able to wiggle all fingers and make a loose fist elbow wrist and hand ROM (range of motion) grossly intact .weight bearing as tolerated to left upper extremity, may use left upper extremity to help balance while using walker, continue left hand elevation, lymphedema glove, and ace bandage for swelling. Surgical Site Care: meplilex border post op dressing, leave dressings in place until outpatient ortho postop visit, two weeks from date of surgery on 1/29/25. R1's Physician Orders Sheets, dated January 2025, did not show orders for weight bearing as tolerated to left upper extremity, continue left hand elevation, lymphedema glove and elastic bandage for swelling, and did not show orders to use a sling. The P.O.S. shows orders entered on 1/24/25 for surgical site care. R1's Nursing Admission assessment, dated 1/21/25, documents left shoulder surgical incision, color normal, temperature warm and moist .and documents no pain. R1's Occupation Therapy Treatment Encounter notes, dated 1/20/25, documents, (R1) given sling for left upper extremity support as her arm is hanging to the side and complaints of significant pain. On 1/21/25 right arm shoulder flex, sling repositioned and hand squeezes. On 1/22/25, right arm shoulder flex, left support put under elbow . nursing notified and aware of pain. On 1/25/25, (R1) very lethargic, difficulty waking up, crying unable to verbalize needs, nursing notified indicating pain in left upper extremity (LUE) .left upper extremity in bad position upon therapist arrival, (R1) on right side with left arm behind her; hand down with increased edema. On 1/28/25, positioning for edema management in left upper extremity. R1's Physical Therapy Encounter Notes, dated 1/21/25, 1/22/25 and 1/23/25, documents R1 bed mobility, sit to stand mobility and bilateral lower extremity and trunk strengthening performed and responding well to treatment. On 1/24/25 working on upper extremity sling management and positioning on edema management. On 1/27/25, exercises with lateral weight shift and one hand support. Sling on LUE (left upper extremity). R1's electronic health record does not show daily assessments were performed on her left upper extremity on 1/20/25, 1/22/25, 1/23/25, 1/24/25, 1/26/25-1/28/25. R1's daily skilled nurses note, dated 1/25/25, documents R1 has the following skin issues: left arm surgery; grasp is equal, upper extremity movement: left side has decreased movement, left arm sling. R1's Medication Administration Record, dated for January 2025, shows to assess pain every shift. Pain scale 0-1 no pain, 2-3 mild pain, 4-5 moderate pain, 6-7 severe pain, 8-9 very severe pain and 10 worst possible pain. R1's M.A.R. shows no pain recorded on 1/20/25 and 1/21/25. On 1/22/25 and 1/23/25 shows a pain level of 4 recorded. On 1/28/25 shows a pain score of 8 (severe pain). R1's Current care plan, initiated on 2/3/25 (after R1's discharge), showed she was admitted with left arm surgical incision, with interventions to observe extremities for signs and symptoms of tissue perfusion touch, report significant findings to physician. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R1's Orthopedic Progress note, dated 1/29/25, documents, (R1) presenting for her first postoperative visit status post left proximal humerus closed reduction with insertion of humeral nail performed on 1/14/25 . grimaces when left arm is examined. (R1's) left arm is in a sling, which was not discharged from hospital with. X-rays obtained today demonstrate left proximal humerus CRIF hardware intact .new fracture noted to the distal 1/3 shaft when compared to 1/15 Xray the humerus distal to the stem in a spiral fashion .Left Upper Extremity: left arm in sling .severe non-pitting edema to left hand .pain with palpation of hand .unable to flex/extend wrist or wiggle fingers. Shoulder ROM (range of mortion): deferred due to pain. The facility's Significant Condition Change and notification Policy stated, To ensure that the resident's family and/or representative and medical practitioner are notified of resident condition changes as those listed below .a significant change in the resident's physical, mental, or psychosocial status .mobility changes, onset of swelling .other abnormal findings .a need to significantly alter treatment .the licensed nurse will contact the resident's representative and their medical practitioner .