

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 06/09/2025
NAME OF PROVIDER OR SUPPLIER Fair Oaks Rehab & Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from significant medication errors. This applies to 2 of 3 residents (R1, R2) reviewed for medications in the sample of 4.</p> <p>The findings include:</p> <p>1. On 6/9/25 at 11:38 AM, R2 was observed in his room sitting in his wheelchair. There were several snacks on his bedside table. R2 said he eats those when his blood sugar is low.</p> <p>On 6/9/25 at 12:11 PM, V6 (Licensed Practical Nurse-LPN) said R2 is a brittle diabetic, and his blood sugars are all over the place. R2 gets long-acting insulin twice a day, and short acting before meals. V6 said she waits to check his blood sugar before meals. V6 stated, (R2's) blood sugar was 133, it's below 150, so he does not get insulin. V6 said she follows the physician orders on how much insulin to administer.</p> <p>On 6/9/25 at 2:41 PM, V9 (R2's Guardian/family member) said R2 is a brittle diabetic, and she does not believe the nurses are giving him the correct insulin doses and the facility is not following the physician orders. V9 said she has expressed her concerns with V1 (Administrator).</p> <p>R2's Endocrinology After Visit Summary, dated 5/15/25, shows orders to increase Tresiba (Long-Acting Insulin) to 70 units at 8:00 AM and decrease Tresiba bedtime dose to 50 units. No need to give the fixed dose of Novolog (short acting insulin). Revise the Novolog scale as follows: (The same report shows it was noted by nursing dated 5/15/25).</p> <p>Blood Sugar Novolog Dose</p> <p>&lt;150 None</p> <p>151-200 6 units</p> <p>201-250 8 units</p> <p>251-300 12 units</p> <p>301-350 14 units</p> <p>351-400 18 units</p> <p>(continued on next page)</p>

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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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>>400 22 units</p> <p>R2's Medication Administration Record (MAR), dated May 2025 and June 2025, shows orders including Novolog Solution 100 Unit/ML (Milliliters) Inject as per sliding scale:</p> <p>If 151-200= 4 units</p> <p>201-250= 6 units</p> <p>251-300= 8 units</p> <p>301-350= 10 units</p> <p>351-400 = 12 units</p> <p>401+ = 14 units, notify POA and MD if over 500. (Start date 4/8/25; DC date 6/7/25). (The MAR does not shows the revised sliding scale orders from 5/15/25).</p> <p>On 6/9/25 at 3:00 PM, V3 (Assistant Director of Nursing/ADON) said nursing should verify all orders are carried out, and confirmed R2's sliding scale orders did not get changed from 5/15/25.</p> <p>2. R1's face sheet shows she is an [AGE] year-old female admitted to the facility on [DATE], with diagnoses including metabolic encephalopathy, COPD, cirrhosis of liver, cognitive communication deficit, acidosis, anxiety, hypertension, occlusion and stenosis of the carotid artery.</p> <p>R1's Medication Administration Record for April 2025 shows orders including Rifaximin (antibiotic) oral tablet 550 mg (milligrams) one tablet twice a day for hepatic encephalopathy. The MAR shows on 4/16/25, R1 did not receive both doses.</p> <p>On 6/9/25 at 1:30 PM, V3 (ADON) said they received a ten day supply of R1's antibiotic (Rifaximin), and the medication was not given on 4/16/25 because they did not have the medication. Nursing should re-order medications at least a few days prior before the last dose.</p> <p>The facility's undated Medication Administration Policy for Senior Living states, All medication orders must be prescribed by a licensed healthcare professional and documented accurately in the residents' medical records .Any changes in medication orders must be documented in the resident's medical record . Medications should be administered according to the five rights of medication use: right resident, right drug, right time, right dose and the right route .</p>