

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 12/12/2025
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, interview, and record review, the facility failed to perform incontinence care for a dependent resident (R3). This applies to 1 of 3 residents reviewed for incontinence care in the sample of 7. The findings include:R3's electronic face sheet, printed on 12/12/25, showed R3 has diagnoses including but not limited to Lennox-Gastaut Syndrome, Epilepsy, autistic disorder, and severe intellectual disabilities.R3's facility assessment, dated 11/24/25, showed R3 has severe cognitive impairment, incontinence of urine and bowel, and dependent on staff for personal hygiene.R3's care plan, dated 8/19/25, showed, (R3) has bladder incontinence due to cognitive impairment and impaired mobility .provide perineal care after each incontinent episode, check frequently for incontinence .On 12/12/25 at 10:10AM, V4 (Certified Nursing Assistant-CNA), V6 (CNA), and V5 (Licensed Practical Nurse-LPN) provided incontinence care for V3. V4 removed R3's toy off his lap and revealed a large wet area on the front of R3's pants. V4 stated R3 got up around 6:30AM and has not been changed since then. R3 was transferred into his bed and rolled to his left side. R3's lift sling was soiled as well as the back of his pants. R3's incontinence brief had a strong urine odor and was saturated with urine. V7 (R1's father) was in the room and confirmed he was in early today, and R3 hasn't been changed since he has been here. V4 and V5 stated residents should be checked at least every 2 hours for incontinence. V5 stated R3 would be high risk for skin breakdown due to incontinence and inability to reposition. On 12/12/25 at 12:25PM, V2 (Director of Nursing) and V1 (Administrator) stated residents should be checked for incontinence at least every 2 hours, if not more often. V1 stated she is shocked R3 was soiled as staff are very attentive to him at all times, as well as his parents when they are visiting. V2 stated R3 is definitely a risk for skin breakdown and should be checked for incontinence often and any refusals should be documented.The facility's policy titled, Pressure Injury Assessment and Treatment, dated 01/2025, showed, F. Risk Factor-Bowel/bladder Incontinence. a. check resident for incontinence as per personalized care plan and clean skin when soiled .The facility stated they do not have an incontinence care policy as of 12/12/25.</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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