STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145702	A. Building B. Wing	03/10/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect a cognitively impaired resident (R7) from sexual abuse by another resident with a known pattern of sexually inappropriate behaviors. R8 was observed with his hand on R7's thigh moving towards her genital area. This failure applies to two of three residents (R7, R8) reviewed for abuse in the sample of 8 and resulted in Immediate Jeopardy.The Immediate Jeopardy began on 3/2/2026 when R8 was observed with his hand on R7's lap moving up towards her private area. V1 (Administrator) was notified of the Immediate Jeopardy on 3/5/2026 at 3:18 PM. The surveyor confirmed by observation, interview and record review that the Immediate Jeopardy was removed on 3/6/2026, but noncompliance remains at level two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.The findings include:The facility face sheet shows R7 was admitted to the facility on [DATE], with diagnoses to include hemiplegia (paralysis) of the right side, aphasia (inability to speak), cerebral infarction (stroke) and dysphagia (difficulty with swallowing). The facility assessment, dated 2/26/2026, for R7 shows her to have no speech, is rarely understood, and has memory impairment. R7 uses a wheelchair to self-propel and requires maximum assistance from staff for her activities of daily living. The care plan for R7, dated 2/28/2026, shows her to have severely impaired decision making and is non-verbal due to history of multiple strokes. The care plan does not show any behaviors for R7.A facility state report dated 3/2/2026 shows R7 was observed by staff in the resident common area and at approximately 6:30 PM. Another male resident (R8) was observed touching R7 in an inappropriate manner.On 3/3/2026 at 3:00 PM, V1 (Administrator) said she was notified of the incident at approximately 6:40 PM by V17 (Agency Nurse). V1 said V17 told her she saw R8 touching R7's thigh and working his way up towards R7's private area. V17 then told V1 that R8 stated R7 was teasing him. V1 said the police and the families of both residents were called as well as the physician. V1 said she told the families the staff were able to stop it before it became inappropriate. V1 said she does not feel it was abuse as it was not willful and R8 did not seek out R7. V1 said R7 has a history of wanting to hold hands with others and will wheel herself over to other people and grab their hands. V1 said R7's family are pressing legal charges against R8. V1 said R7 and R8 have been placed on 15-minute checks. On 3/4/2026 at 7:45 AM, V1 said the police came back the night before and served R8 with papers to appear in court. V1 said he is being charged with criminal sexual abuse.The notice to appear signed by R8 on 3/3/2026 shows he is to appear in court for the charges of criminal sexual abuse.On 3/4/2026 at 9:03 AM, this surveyor was in the hall near the resident common area and saw R7 and R8 holding hands. There were numerous staff present near the area, walking by and standing at the nursing station talking. No staff intervened until V1 saw this surveyor standing near the situation and was alerted to R7 and R8 holding hands. V1 said she was placing R8 on a 1:1 observation.On 3/4/2026 at 10:54 AM, V17 (Licensed Practical Nurse-LPN, Agency Nurse) said she was the nurse assigned to R8 that night. V17 said she was at the nursing station across from the residents' common area and she looked up and saw R8 with his hand on R7's thigh and he was moving his hand up to her private area. V17 said she immediately separated the (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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	residents, called for the nurse for R7, and asked R8 to leave the common area. V17 said R8 was yelling and cursing at her and said R7 was teasing him. V17 said when R7's nurse came to get the resident, he told her that earlier in the shift, R8 wanted R7 brought closer to him, and he took R7 to the other end of the building away from R8. V17 said if she had known this, she certainly would have kept a closer eye on the situation and kept female residents away from R8. V17 said the police responded right away and spoke with R8. On 3/3/2026 at 3:30 PM, V11 (Registered Nurse-RN) said on 3/2/2026 at around 5:00 PM, he was near the resident common area and heard R8 yell out to staff to bring R7 over to him and he would help calm her down. V11 said R7 was trying to stand up on her own. V11 said he took R7 to the other nursing unit to keep her away from R8 due to the history R8 has with female residents. V11 said R7 likes to hold hands with anyone and will roll up to them and grab their hands. V11 said R8 has a history of inappropriate behavior with other female residents. V11 said he has been caught touching and kissing other female residents. On 3/4/2026 at 12:30 PM, V22 (Social Services) said R8 likes to chat up the ladies. V22 said R8 does not social distance and likes to hold hands with another female resident (R6) who has dementia and has a history of hand holding with male residents and staff. V22 said R8 has had other incidents of kissing R6. V22 said R7 is new to the facility and likes to hold hands with other staff and residents. V22 said R7 would be the one to go up to R8 and grab his hands. V22 said he has spoken with R8's son and he said his father has always been a ladies' man and liked to frequent bars and chase the ladies. On 3/4/26 at 12:46 PM, V14 (R7's Daughter) said, My mom's nurse called me that night to let me know. He said there was an incident with one of the other residents and my mom, that he was trying to get into her pants and that one of the nurses had seen what was happening and split them up. She has only been at the facility for about two and a half weeks. She can move her wheelchair with her feet. My mom doesn't speak; she has global aphasia so she can't tell you how she is feeling. Before she had her medical issues, she would have yelled and screamed about this happening to her. She had a stroke, so her right side is weak. If she didn't have any of that, she would have jumped up and gotten away from him. They said they are going to keep him away from her and that they would be checking on him every 15 minutes to see where he is, because my mom can't be in her room by herself, due to her fall risk, they put her in that little tv room next to the nurses' desk. I told them I don't want that guy there anymore; I don't need to be worrying that my mom is going to be harmed. It makes me feel bad because I feel like I put her in a place to be harmed. A call was placed to V31 (the responding police officer) with no return call. A Freedom of Information Act request was made for the police report, and a redacted copy was obtained. The report written by V31 was dated 3/2/2026 at 7:19 PM. V31 documented he was called to the facility for a disorderly resident. V31 interviewed the nurse who told him she witnessed a male resident's hand on a female resident's lap, inside her pants and around the area of her vagina. The report shows the nurse said he did not touch the vagina but was close to it and she stopped it from happening. The nurse stated the male resident became verbally aggressive with her and when she took him to his room, he told her the other resident had aroused him. The nurse stated the female resident cannot speak or move very well so there is no way she would have given consent. The report then shows an interview with the male resident saying he was aware of why the police were there, but he did not do anything. The male resident understood what was being said and was coherent. At first the male resident said he was sitting across from the female resident, and she placed her hand on his hand. The male resident understood the female resident could not speak and he stated she is new to the building. The male resident then changes his story and stated he reached over and grabbed her hand and had his hand placed on her lap. He added he would never touch anyone in their private area. He said all he did was rub around her thigh and lap, but nothing sexual happened. V31 then spoke with a witness; a resident of the facility who said he was watching TV and the male and female resident were behind him. The resident said he turned his head back and saw the female resident swat away the hand of the male resident. He then heard a nurse yell, and he knew something was wrong. He then heard the male resident and the nurse argue. The resident stated this is not the first (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	time the male resident has done this, he has touched other female residents in inappropriate areas. When they are sitting in the TV room watching TV, and the male resident see's something on TV, like a woman, he begins to talk dirty. V31 then spoke with a second nurse who said this is not the first time this has happened, a few weeks ago he made out with another female resident who suffers with dementia. The nurse said he feels the male resident is aware of what he is doing and earlier that night the male resident wanted me to bring the female resident to him, he added this was unusual but did not take the female near the male resident. V31 then spoke with a CNA (Certified Nursing Assistant) who said she has seen the male resident engage in multiple instances of inappropriate touching with other residents. She had observed the male resident touch female residents around their breasts and mentioned kissing another resident on the mouth. On 3/5/2026 at 9:59 AM, a return call to V17 was made to clarify her statement. V17 said R8's hands were not inside R7's pants. His hands were on the outside of her clothing. V17 said R7 was wearing black pants and an incontinence brief. V17 said she did not tell the police his hands were inside her clothing. Review of R8's clinical record shows he was started on Depo-Provera (a hormonal medication of the progestin type) on 8/1/2025 for abnormal sexual behavior. The injection was ordered to be given to R8 every 3 months. On 3/5/2026 at 8:10AM, V2 (Director of Nurses-DON) said she was not aware of why R8 was started on Depo-Provera. On 3/5/2026 at 8:20 AM, V22 (Social Services) said he was not aware of when or why the Depo-Provera was started. V22 said he does not know who ordered it or why. A Physician progress note, dated 7/14/2025, shows V16, (R8's Primary Care Physician), ordered the Depo-Provera due to staff stating inappropriate sexual behavior towards female residents.On 3/5/2026 at 11:40 AM, V16 (R8's Physician) said he is not too familiar with him, but name sounds familiar. I don't remember any specifics. Given the history they gave me, I don't remember what happened, but if there is abnormal sexual behavior, Depo-Provera is the first go-to medication to stunt those very heavy, abnormal hormone surges in hopes to decrease the urge for him to go into those kinds of behaviors. After some time if it is not working, you would also have to consider psychiatric behaviors and add antipsychotics as a last resort because they are risky medications. I don't remember the patient or the details of what happened, but this is a routine medication for taking care of patients with these kinds of problems. If they described behaviors that were unwanted, no matter what it is, sexually inappropriate is sexually inappropriate, it doesn't matter how they describe it. Rubbing of legs and hands is inappropriate, and you would need to do something, and that would be the first medication that you would give. I would expect them to have closer supervision of those patients until the behaviors are all done, and they responded well to the treatment. They need to keep an eye on these patients until they don't pose a risk to other residents. A review of progress notes for R8 shows on 8/5/2025, R8 was observed by family touching the abdomen of a female resident. On 1/7/2026, R8 was observed kissing the hand of another female resident. A progress note, dated 1/10/2026, shows R8 was observed following a female resident around the front room, the female tried to move multiple times but R8 continued to follow her and was trying to hold her hands and rub her arms. On 2/6/2026, a note was written by V22 (Social Service Director) stating R8's son was notified of R8 kissing a female resident on the mouth. A review of the nursing progress notes for R6 shows on 3/14/2025, R6 and R8 were observed in R8's room and were being Sexually inappropriate. Nurse V11 was contacted and he said he does not remember the incident, it was last year. The facility face sheet for R8 shows he was admitted to the facility with diagnoses to include congestive heart failure, chronic pulmonary disease, osteoarthritis and depression. The facility assessment, dated 1/21/2026, shows him to have mild cognitive impairment, shows no behaviors and requires supervision with his activities of daily living. The care plan for R8 shows he may be socially inappropriate with other residents, dated 2/27/2025. On 3/20/2025, an intervention was added stating do not allow him to be unsupervised with female residents. On 2/27/2025, an intervention to intervene to protect the rights and safety of others, remove from the situation and take to alternate location as needed. The facility face sheet for R6 shows she was admitted to the facility with the diagnosis of Alzheimer's Disease. The facility (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	assessment, dated 2/10/2026, shows her to have severe cognitive impairment and requires moderate assistance from staff for her activities of daily living. A care plan, with a revision date of 2/12/2026, for may make sexual inappropriate comments of advances towards male staff and residents. Interventions include if found making inappropriate physical advances, remove her from the situation immediately. The behavior monitoring tool used by the facility shows no behaviors were observed for R6, R7, or R8 for the last 30 days. The undated facility abuse policy shows each resident has the right to be free from abuse. Definitions of sexual abuse is sexual behavior exhibited by one person or another without consent or the capacity to consent. This includes kissing and hugging. Resident behaviors are monitored for changes that trigger abuse behaviors. Our facility will reassess care plan interventions on a regular basis. Intervention strategies based on resident screenings will be implemented to prevent occurrences of abuse. Our facility will remove any alleged perpetrator from any further contact with any resident. The facility presented an abatement plan on 3/5/2026 at 3:46 PM. The survey team reviewed the abatement plan and was unable to accept the plan to remove immediacy. The abatement plan was returned to the Administrator for revisions. The facility presented a revised abatement plan on 3/5/2026 and the survey team accepted the revised plan on 3/5/2026 at 4:00 PM. The Immediate Jeopardy that began on 3/2/2026 was removed on 3/6/2026 when the facility took the following actions to remove the immediacy:Identification of residents that have the potential to be affected by the deficient practice:Female residents with a cognitive deficiency have the potential to be affected by this deficient practice. Immediate actions implemented to decrease resident risk:*R8 has been placed on one-on-one care until his discharge on [DATE]. *The female residents that gravitate to him have been identified and are being closely monitored to ensure staff are following care plans for interventions. *The DON or Designee has educated nursing staff regarding R8's one-on-one status as well as the need re-direct females from his vicinity while he remains in the facility. All staff will be educated prior to working their next shift. *The Social Service Director or Designee will educate all staff on the abuse policy and procedure including how to identify inappropriate sexual behavior with a focus on residents that don't have the cognitive ability to consent. All staff will be educated prior to working their next shift. *The DON or Designee has educated nursing staff on where to find the care plan of residents to include any interventions for behaviors. All staff will be educated prior to working their next shift. *Beginning 3/6/26, all behaviors will be reviewed in the morning clinical meeting to ensure proper interventions are put into place and the care plan is updated to reflect such. The DON or Designee will then make sure any changes to either are communicated to the staff.*Ad Hoc QAPI meeting will be held on 3/6/2026 with QAPI team members in person and Medical Director (V16) via phone. The abuse policy and procedure as well as the state regulation was reviewed and the measures being put in place to ensure this deficient practice doesn't happen again.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to have isolation signs on the doors of two residents on isolation. This applies to 2 of 3 residents (R2,R3) reviewed for infection control in the sample of 8.The findings include: The facility face sheet for R2 shows she was admitted to the facility with diagnoses to include Parkinson's, surgical site aftercare and urinary tract infection. The facility assessment, dated 12/17/2025, shows R2 to be cognitively intact and requires moderate assistance with her activities of daily living. A Physician order dated 12/12/2025 shows an order for enhanced barrier precautions.The facility face sheet for R3 shows he was admitted to the facility with diagnoses to include surgical aftercare, pressure ulcers, type 2 Diabetes, and wound infections. The facility assessment, dated 1/22/2026, shows him to be cognitively intact and requires partial assistance with his activities of daily living. A Physician order, dated 11/4/2025, shows R3 is to be on contact isolation. A care plan, dated 11/6/2025 with a revision date of 12/19/2025, shows R3 requires strict isolation precautions.On 3/3/2026 at 1:00 PM, no signs for isolation were observed on the doors of R2 or R3.On 3/3/2026 at 1:30 PM, V2 (Director of Nursing) said R2 and R3 both have orders for Enhanced Barrier Precautions (EBP) and should have signs on their doors to alert staff to use personal protective equipment (PPE) to prevent spread of infections. R3 is no longer having diarrhea, and his contact isolation was changed to EBP. V2 said, That's my bad, the signs should have been moved with the residents when they switched rooms.The undated facility policy for infection prevention and control manual-enhanced barrier precautions shows EBP are an infection control intervention designed to reduce the transmission of multi-drug-resistant organisms in nursing homes. EBP involves the use of a gown and gloves during high contact resident care.