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	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Oaks Rehab & Healthcare	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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to assess a resident's need for siderails for positioning/bed mobility before removing them for 4 of 16 residents (R47, R42, R26 and R23) reviewed for accommodation of need in the sample of 16. The findings include:1.On 9/8/25 at 10:00 AM, R42 was lying in bed. R42 did not have siderails or assist bars on his bed. V26 (R42's Father) said he is upset the facility came in about a week or so ago and took his siderails off. V26 said R42 would use his siderails to help turn in bed, and it was good therapy for him. R42's Rehab Data Report, dated 8/18/25, shows diagnosis of: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. R42 requires substantial/maximal assistance to roll from left to right while in bed. On 9/9/25 at 3:01 PM, V2 (Director of Nursing) said everyone in the whole building had siderails, and they went around and removed all of them due to risk for entrapment. V2 said their plan is to have therapy assess each resident to determine their need for siderails for positioning, but they have not done that yet. V2 said she knows for sure R42 needs siderails to help with positioning and mobility. 2. On 9/8/25 at 10:03 AM, R47 was sitting in a wheelchair in his room. R47's bed did not have siderails or assist bars on it. R47 said they took his siderails off and told him he could not have them. R47 said now he has nothing to assist him in turning in bed. R47's Functional Abilities and Goals Assessment, dated 8/20/25, shows he requires partial/moderate assistance to roll from left to right in bed. On 9/10/25 at 9:28 AM, V2 (Director of Nursing) said R47 is able to use his siderails for bed mobility. 3. On 9/8/2025 at 10:27 AM, R26 said she is going to complain because they took the siderails off her bed. R26 said now she cannot use them to roll herself in the bed. R26 had no bedrails on her bed. R26's Functional Abilities and Goals Attestation, dated 9/4/25, shows R26 has no functional limitations to her upper or lower extremities for range of motion and requires substantial/maximal assistance to roll left and right. R26's Resident Bed Rail/Enabler Consent Form, dated 3/25/25, was signed by R26, and shows the request was prepared by R26 while being mentally capable of participation in her own health care decisions. It shows R26 consents to the utilization of bed rails/enablers for her care. 4. On 9/9/25 at 8:46 AM, R23 said she had a different bed a week or so ago and they came in and removed all the side rails. R23 said she was not given the option to keep her siderails on her bed and she needs them to turn or raise up in bed. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R23's Functional Abilities and Goals Attestation, dated 2/9/25, shows R23 has no functional limitations to her upper or lower extremities for range of motion and requires supervision or touching assistance to roll left and right. On 9/9/25 at 3:01 PM, V2, Director of Nursing (DON), said everyone in the whole building had bed rails. They went through and removed all of them, and the plan is for therapy and herself to assess each resident to see if the siderails are truly needed for positioning purposes. The facility's Bed Rails Policy (approved 12/2024) shows when a bed has a pre-installed rail, the facility must determine whether disabling the rail would pose a risk to the resident.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure the pureed meal was prepared in a smooth consistency. This applies to 6 of 6 residents (R49, R56, R65, R20, R33, R42) reviewed for therapeutic diets in the sample of 16. The findings include: On 09/08/25 at 10:08 AM, V6 (Cook) placed seven hamburger patties in the food processor, added seven scoops of thick processed cheese product, and blended. V6 then added three additional hamburger buns and three scoops of liquid broth, blended, and then added four more buns and several additional scoops of liquid broth. The food processor was full to the brim of the puree cheeseburger. V6 and V5 (Dietary Manager) sampled the pureed cheeseburger and V5 stated, I think a little more blending and maybe blend half of it at a time. V6 did not remove 1/2 of the puree meal from the food processor and continued to blend the pureed cheeseburger approximately 30 more seconds and then sampled the puree and said, it's good and placed it in the steam tray. On 09/08/25 at 12:15 PM, a sample tray of the pureed meal was provided. The cheeseburger puree appeared thick and lumpy on the plate. This surveyor sampled the pureed cheeseburger; it was thick, pasty, with bits present, using the tongue to remove the lumpy puree stuck on the upper palate of the mouth. The puree cheeseburger was not a smooth consistency. At 12:30 PM, V5 sampled the puree cheeseburger and said there are nibbles and it's not smooth as pudding. V5 said V6 was following the recipe and was nervous. V5 said he instructed her to separate the amount being pureeing; it was too much at one time. The facility's undated list provided on 9/9/25 shows R49, R56, R65, R20, R33, R42 receive a puree therapeutic diet. The facility's Burger Cheeseburger on Bun [NAME] puree recipe shows prepare products separately if possible in a food processor, bun product until smooth.gradually add stock in a thin stream to bun mixture and blend until thoroughly pureed, no lumps or bits.prepare meat product.blend meat product in a food processor until finely ground.gradually add beef stock in a thin stream to finely ground meat in food processor and continue to process product until the product is completely pureed (smooth no lumps or bits).combine milk and margarine, gradually add milk and margarine in a thin stream to cheese mixture and blend until thoroughly combined.Pureed Food Preparation undated Policy undated states, Pureed food will be prepared using standardized recipes to ensure quality, flavor, palatability and maximum value.pureed foods will be the consistency of applesauce or smooth, mashed potatoes.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure a resident was assessed to be able to self-administer medications. This applies to 1 of 16 residents (R50) reviewed for medication self-administration in a sample of 16.The findings include:On 9/8/25 at 9:35 AM, R50 was talking with a visitor. R50 used an inhaler and placed the inhaler in a lock box on their nightstand. R50 stated she had been storing it in the box for a while.R50's Physician Orders showed an order for Albuterol-Budesonide Inhalation Aerosol 90-80 to be given 1 puff inhaled orally every 4 hours as needed for shortness of breath related to chronic obstructive pulmonary disease. There is no physician order for R50 to self-administer the inhaler.R50's medical record showed no assessment or care plan pertaining to self-administering medications at the time of the survey.On 9/10/25 at 8:30 AM, V2, Director of Nursing, stated residents need to be assessed, care planned, and have a physician order to self-administer medications.The facility's Self-Administration of Medication Policy, dated 04/2021, showed the facility's interdisciplinary team will assess the resident for the ability to take the medication correctly, obtain a physician's order for the resident to self-administer specific medications, and place appropriate documentation in the resident's medical record.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure a Stage III pressure wound was assessed for 1 of 4 residents (R1) reviewed for pressure wounds in the sample of 16.The findings include:On 9/8/25 at 9:55 AM, R1 was observed to have dressing to her right posterior thigh. R1 said it was not caused by her accident; her skin splits there sometimes.On 9/9/25 at 10:10 AM, V4, Wound Care Nurse, said if there a new skin condition, the CNA (Certified Nursing Assistant) will notify the nurse, and the nurse will assess it and notify her. V4 said she will assess it as soon as she is informed, usually the same day, sometimes the next day, but within 24 hours. V4 said she is aware of R1's right posterior thigh wound. V4 said she did not do an assessment and did not document the wound measurements. On 9/9/25 at 11:34 AM, V25, said R1's right posterior thigh wound is a pressure ulcer. V25 said it goes from open to healed frequently, and was closed for a long time. V25 said every time is reopens, it remains a Stage III pressure ulcer. R1's Skin Check Weekly & PRN form, dated 9/4/25, shows R1 has a new area of skin impairment to her right thigh denoted and open area of site 35) Right thigh (rear). The facility was not able to provide an assessment from their wound care nurse complete with measurements for the wound as of 9/9/25 at 2:00 PM after it was identified on 9/4/25. A document provided by the facility on 9/8/25 listing all the residents with wounds in the facility (undated) does not show any wound(s) to R1's right thigh. R1's Progress Note from V25 from her weekly visit conducted on 9/2/25 does not include any right thigh wound(s).

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement nutritional interventions for a resident who is underweight for 1 of 5 residents (R12) reviewed for nutrition in the sample of 16. The findings include: R12's Face Sheet shows that she admitted to the facility on [DATE], with a diagnosis of moderate protein-calorie malnutrition and dementia. R12's Weights and Vitals Summary shows a weight of 77 pounds on 8/17/25. R12's Dietitian Note dated 8/19/25 shows, Resident screened for malnutrition, at risk per MNA score.Varied intake at meals, consuming 25-100% per chart review. Current weight: 77#. BMI (Body Mass Index): 14.1, underweight.REC (recommendations): MedPass 60 mL (milliliters) TID (three times a day) between meals for varied PO (oral) intake / underweight.R12's Nutrition Diagnosis Criteria Form, dated 8/19/25, show 2 Cal Med Pass of 60 mL three times a day is recommended as a nutritional intervention. This recommendation was signed as approved by the provider. R12's Physician's Order Sheet does not document an order for MedPass three times a day. R12's September Medication Administration Record does not show that MedPass was given. On 9/8/25 at 12:00 PM, R12 was in the dining room. R12 appeared very thin. R12 ate one cookie from her meal tray and then said she is no longer hungry and was done eating. On 9/9/25 at 8:15 AM, R12 was in the dining room. R12 breakfast tray was in front of her, but she was sleeping. R12 was approached multiple times to try and wake her up, but she would not wake up and eat. At 8:30 AM, R12 was brought out of the dining room and did not eat breakfast. On 9/10/2025 at 10:08 AM, V27 (Dietitian) said she did R12's initial assessment when she was admitted . V27 said she gave the recommendation for a supplement due to R12's low weight and history of a decreased appetite. V27 said =with any recommendations, she completes a form, and it is sent to the team and if they agree, the facility puts the orders into the computer.On 9/10/25 at 9:28 AM, V2 (Director of Nursing) said she does not know what happened with R12's nutritional supplement. V2 said they received the recommendation form, it was signed by the provider, and then scanned into R12's chart, but the order did not get placed into the system. The facility's undated Nutritional Assessment and Monitoring Policy shows, The Dietary Manager or RD (Registered Dietitian) will complete a comprehensive nutritional assessment according to the admission date and MDS schedule. The Individualized plan of care will be written and reviewed regularly when changes are noted.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure a resident received pain medication as ordered to achieve adequate pain control for 1 of 16 residents (R60) reviewed for pain management in the sample of 16. The findings include: R60's Face Sheet shows diagnoses of: chronic pain, pain in left foot, ankle and joints, bone transplant, osteoarthritis of left foot and ankle, dislocation of tarsal joint of left foot, contracture of left foot, non-pressure chronic ulcer of left foot, joint disorder of left ankle and foot, and aftercare following joint replacement surgery.R60's September Medication Administration Record shows an order for oxycodone 5 mg (milligrams)-1-2 tablets every 4 hours as needed for pain, 1 tablet for pain from 1-5, 2 tablets for pain 6-10. R60's Oxycodone Controlled Substance Sheet shows from 9/3-9/6, R60 took 10 tablets of oxycodone daily. The sheet shows on 9/7 at 4:20 PM, she had only 7 pills left. R60's Care Plan shows she has pain due to: status post left achilles Tenotomy, presence of external fixator, left ankle contracture and chronic pain. The interventions show, Administer analgesia as per orders.On 9/8/2025 at 10:45 AM, R60 was lying in bed. R60 said she had pain in her right lower extremity that she rated at a 9 out of 10. R60 said they constantly run out of her pain medications and say they are waiting on a prescription from her doctor. R60 said she is not due for more pain medication until 1:00 PM. On 9/8/25 at 2:54 PM, R60 said she got half of her dose of pain medication due to them running low. R60 said the nurse came in and told her that her pain medication was running low, and he was going to give her one pill and some Tylenol instead of the two she is supposed to have. R60 said she really wanted the two due to her severe pain, but she agreed. R60 said her pain is still at a 9 out of 10 in her right leg. R60 was wincing and grimacing in pain throughout the conversation. On 9/8/25 at 2:58 PM, V30 (Registered Nurse) said R60 was due for her oxycodone and he had heard that the night nurse sent in a request for a refill, but he had not received it yet. V30 said he went to R60 and told her she only had three pills left and offered one pill along with some extra Tylenol, and she was ok with the plan. V30 said she was rating her pain at a 7 out of 10 at that time. On 9/9/25 at 2:29 PM, V2 (Director of Nursing) said controlled substances require the prescriber to send in a new prescription with every refill. V2 said when a resident has about 7 pills left, the staff should re-order the medication. V2 said if the medication is ordered in the morning, they will get it from pharmacy that same day. V2 said if they run out of a medication that is needed before the refill has arrived, they can get the medications from the convenience box or call pharmacy for a stat delivery. V2 said if either of those options do not work out, they can pick up the prescription from the local pharmacy. V2 said the resident should never have to go without pain medications or have to choose one pill or two due to running low. The facility's Pain Management Policy shows, It is the policy of this facility to respect and support the resident's rights to optimal pain assessment and management.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure 1 of 16 residents (R46) ingested their medications in the sample of 16 residents reviewed for pharmacy services.The findings include:On 9/8/25 at 10:36 AM, R46 was lying in bed on his left side. Two pills were on his bed covers. On 9/8/25 at 10:42 AM, V24, Registered Nurse (RN), said the nurse should always watch to make sure a patient swallows their medications. V24 approached R46's bed and removed the two pills from his linens. The facility's Medication Administration Policy for Senior Living (undated) shows staff members must ensure that residents have swallowed or otherwise received the medication properly.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on observation, interview, and record review, the facility failed to ensure pharmacy recommendations were addressed and/or implemented for 1 of 5 (R23) residents reviewed for monthly medication review in the sample of 16. The findings include: The findings include:On 9/9/25 during the morning medication pass which began at 8:23 AM, V31, Licensed Practical Nurse/LPN administered R23 Trelegy Ellipta via inhalation. V31 did not instruct or encourage R23 to rinse her mouth following the inhaled medication.R23's Pharmacy Medication Regimen Review, dated 7/20/25, shows the following: Resident has an order for the following inhaled corticosteroid: Trelegy Ellipta. To prevent oral candidiasis (thrush) caused by the inhaled corticosteroid, ensure the resident rinses their mouth with water (swish and spit) after each inhalation. Please consider adding this to the order on the MAR (Medication Administration Record). On 9/10/25 at 11:05 AM, V2, Director of Nursing (DON), said once the pharmacy reviews the residents medications, they get the recommendations the next day. They present the recommendations to the Nurse Practitioner (NP); V32/NP, addresses the recommendations within a couple days, and the facility processes them and implements any changes, as appropriate right away, meaning within a day or two.The facility's Pharmacist Consultant Policy and Procedure (revised 04/21) shows the pharmacist recommendation(s) will be reported to the DON, attending physician, and/or nurse on duty immediately that day. It is the facility's responsibility to assure that every pharmacist recommendation is responded to as mandated by the current regulations. If the recommendation is declined, rationale must be documented as to the reason.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to administer medications as ordered at the correct time and the correct location. There were 47 opportunities with 7 errors resulting in a 14.89% error rate. This applies to 2 of 4 residents (R23 and R64) observed in the medication pass.1.R64's Face Sheet shows diagnoses of: generalized osteoarthritis, diabetes mellitus, and hypertension. R64's September Medication Administration Record shows orders for: Lidocaine External Patch 4%-Apply to right elbow one time a day for right elbow pain to be applied at 8:00 AM, Vitamin D3 10 MCG (micrograms)-2 tablets by mouth one time daily at 8:00 AM, labetalol 100 MG (milligrams)-1 tablet by mouth twice daily at 8:00 AM and 8:00 PM for hypertension, and Insulin Lispro-inject per sliding scale subcutaneously with meals at 8:00 AM, 12:00 PM and 5:00 PM for diabetes mellitus. On 9/9/25 at 8:59 AM, V29 (Registered Nurse) started preparing R64's 8:00 AM medications. V29 omitted R64's 8:00 AM dose of labetalol and Vitamin D. At 9:23 AM, R64 was sitting in his chair in his room. R64's breakfast tray was on his bedside table, uneaten. R64 said he was finished with his tray and was not going to eat anything. V29 checked R64's blood sugar and it was 207. At 9:30 AM, V29 administered R64's insulin, provided R64 his prepared oral medications, and put his lidocaine patch on his left elbow. 2. On 9/9/2025, observation of R23's morning medication administration began at 8:23 AM. V31, Licensed Practical Nurse (LPN), prepared and administered R23's medications, however, three medications were omitted (Biotin 5 mg (milligrams), Pantoprazole sodium delayed release 40 mg, and Venlafaxine HCL extended release). V31 said each of the three medications named above were gone and would need to be reordered. R23's Order Summary Report, dated 9/10/25, shows current, active orders for Biotin oral capsule 5 mg give one time a day, Protonix (pantoprazole sodium) 40 mg give my mouth one time a day, and Venlafaxine HCL ER oral tablet extended release 24 hour 75 mg give two tablets by mouth one time a day. R23's Medication Administration Record (MAR) for September 2025 shows the three medications described above were each scheduled to be given at 8:00 AM each morning. On 9/10/25 at 11:57 AM, V2 (Director of Nursing) said when nurses are preparing medications, they should ensure the right dose, right medication, right time, right route, and right resident are followed. V2 said the nurse should give all ordered medications at the time they are ordered but can be given one hour before and up to one hour after the ordered time. V2 said if the nurse is out of a medication, they should check to medication room if it is a stock medication, or the convenience box if it is a prescription medication. V2 said the ordered location should always be followed for pain patches. V2 said insulin should be given at the time they get their meal, or right before they eat. The facility's Medication Administration Policy for Senior Living (undated) shows medications should be administered according to the five rights of medication use: right resident, right drug, right time, right dose, and the right route.

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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 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 ensure Personal Protective Equipment (PPE) was used when providing care to residents on contact isolation or enhanced barrier precautions to prevent the spread of infections for 2 of 16 residents (R8 and R63) reviewed for infection control in the sample of 16. The findings include: 1.R8's Physician's Order Sheet shows he is on Contact Isolation for Carbapenem-Resistant Acinetobacter Baumannii (CRAB). On 9/8/25 at 9:08 AM, R8 had a sign on his door that showed he was on contact isolation. V18 (Certified Nursing Assistant) entered the room with no PPE on. At 9:10 AM, V18 exited the room holding unbagged soiled linens in his hand and arm, and disposed of them in a cart in the shower room. On 9/8/25 at 2:08 PM, V2 (Director of Nursing) said if a resident is on contact isolation, the staff should wear gloves and a gown when entering the room, and should dispose of all linen in the linen container in the room. The facility's Infection Prevention and Control Manual-Transmission-Based Precautions Policy shows, Procedure for Contact Precautions.Wear gloves whenever touching the resident's intact skin or surfaces and articles near the resident.Don gloves upon entry into the room or cubicle.Don gown prior to entry into the room or cubicle.After gown removal, ensure that clothing and skin do not contact potentially contaminated environmental surfaces that could result in possible transfer of microorganisms to other residents or environmental surfaces. 2. On 9/8/25 at 10:45 AM, R63's catheter bag was hanging on the side of the bed. R63 stated they had the catheter for few weeks to help decrease skin irritation. R63's room was not identified with an Enhanced Barrier Precautions (EBP) sign. When asked if the staff wear isolation gowns when they come in the room to perform care takes (hygiene, catheter care, repositioning), R63 stated, Not since I had the catheter. The staff have just been wearing gloves. On 9/9/25 at 9:20 AM, V17, Licensed Practical Nurse (LPN), entered R63's room with no isolation gown on. V17 had to adjust R63's gown and bedding to access R63's arm. V17 then administered R63's insulin dose. On 9/9/25 at 9:30 AM, V17 stated R63 should be on EBP for having a catheter. V17 stated the personal protective equipment (PPE) for EBP is a gown and gloves when performing cares with a resident. V17 stated they should have worn a gown when the gave R63's insulin. V17 verified R63's room did not have an EBP sign. R63's physician orders, printed on 9/9/25, showed R63 has an order for EBP initiated on 4/6/25 regarding wounds. R63 physician orders showed R63 has an order for a urine catheter, with a start date of 7/25/25. On 9/9/25 at 1:00 PM, V2, Director of Nursing, stated PPE used for EBP isolation is gown and gloves for direct care. The facility's undated EBP policy showed on of the reasons a resident should be placed on EBP isolation is when they have a medical device which includes urinary catheters.