

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145917	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER Fair Oaks Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 471 Terra Cotta Avenue Crystal Lake, IL 60014	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>45540</p> <p>Based on interview and record review the facility failed to notify the physician of resident's rash on the day it was identified. This applies to 1 of 4 (R1) in the sample of 4 reviewed for notification.</p> <p>The findings include:</p> <p>On 3/10/2025 at 9:44AM, V6 Physical Therapy Assistant (PTA) stated she worked with [R1] on 2/21/2025 and [R1] mentioned she had a rash on her neck. V6 stated she did see a blotchy red area on her neck and believes she reported to the nurse but was unsure who she reported it to.</p> <p>On 3/10/2025 at 10:39AM, V8 Registered Nurse (RN) stated she vaguely remembers [R1]. V8 stated nobody mentioned a rash to her that day. V8 stated she would have called the doctor if the resident did in fact have a rash.</p> <p>On 3/10/2025 at 12:17AM, V11 Nurse Practitioner (NP) stated she was not notified of [R1's] rash until 2/25/2025 right before [R1] was being discharged .</p> <p>On 3/10/2025 at 1:30PM, V1 Administrator stated the facility did not have documentation of a provider notification for [R1] on 2/21/2025.</p> <p>The facility failed to provide documentation a physician or provider was notified of [R1's] rash that was identified on 2/21/2025.</p> <p>The facility provided Acute Condition Changes - Clinical Protocol policy revised 3/2018 states, . Direct care staff, including nursing assistants will be trained in recognizing subtle but significant changes in the resident (for example, . changes in skin color or condition) and how to communicate these changes to the Nurse. the nursing staff will contact the physician based on the urgency of the situation . the nurse and physician will discuss and evaluate the situation.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>45540</p> <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and record review the facility failed to assess a resident after a rash was observed by staff. This applies to 1 of 4 (R1) in the sample of 4 reviewed for assessments.</p> <p>The findings include:</p> <p>On 3/10/2025 at 9:44AM, V6 Physical Therapy Assistant (PTA) stated she worked with [R1] on 2/21/2025 and [R1] mentioned she had a rash on her neck. V6 stated she did see a blotchy red area on her neck and believes she reported to the nurse but was unsure who she reported it to.</p> <p>On 3/10/2025 at 10:39AM, V8 Registered Nurse (RN) stated she vaguely remembers [R1]. V8 stated nobody mentioned a rash to her that day. V8 stated she would assess the resident if someone told her about a rash and call the doctor if the resident did in fact have a rash.</p> <p>On 3/10/2025 at 10:19AM, V7 Infection Control Preventionist stated if a resident has a rash it is reported to her by the nurse, and she would follow up. V7 stated the physician should be involved so they can assess it as well and see what treatments is needed for it. V7 said assessment and notification should happen on the same day.</p> <p>On 3/10/2025 at 1:30PM, V1 Administrator stated the facility did not have documentation of a skin assessment for [R1] on 2/21/2025.</p> <p>The facility failed to provide documentation an assessment was completed after the rash was identified on 2/21/2025.</p> <p>The facility provided Acute Condition Changes - Clinical Protocol policy revised 3/2018 states, . Direct care staff, including nursing assistants will be trained in recognizing subtle but significant changes in the resident (for example, . changes in skin color or condition) and how to communicate these changes to the Nurse.</p>		