STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145917	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Oaks Health Care Center	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to perform a safe wheelchair transport for a high fall risk resident for 1 of 3 residents (R1) reviewed for safety in the sample of 4. This failure resulted in R1 falling forward from the wheelchair and sustaining a broken nose and a laceration to his forehead that required sutures.Findings Include:On 10/9/25 at 10:10 AM, V9 (Certified Nursing Assistant -CNA/Restorative Aide) pushed R1 in his wheelchair from the dining room to a seating room without footrests in place. R1's shoes came in contact with the floor four times during the transport of approximately 25 feet. R1 was well groomed with a bandage on the middle of his forehead. R1 had a privacy bag for his indwelling catheter directly under the seat of his chair. The surveyor asked R1 how he hurt his head. R1 replied, He (V6 - CNA) was giving me a ride from the dining room to my room and suddenly this (touching his wheelchair) stopped, and I kept going. I hit my head on the floor. The surveyor asked R1 if he had footrests on his wheelchair. R1 said there were footrests, but they haven't used them on his chair in a while. R1 said he usually tries to pick up his feet, but the footrests do keep his feet from hitting the floor. R1 said his feet might have fallen and that could have stopped the chair. R1 denied refusing footrests to be placed on his wheelchair when staff propel him.R1's Face sheet dated 10/9/25 showed diagnoses to include, but not limited to diabetes; asthma; neuromuscular dysfunction of the bladder; dysphagia (difficulty swallowing); dementia; CHF (congestive heart failure); anemia; CKD (chronic kidney disease - Stage 3); muscle wasting and atrophy; abnormalities of gait and mobility; need for assistance with personal care; atrial fibrillation; and generalized osteoarthritis. R1's facility assessment dated [DATE] showed he was cognitively intact. R1's Final Incident Report dated 10/8/25 showed, on 10/5/25 at approximately 8:30 PM, a CNA (V6) was transporting R1 back to his room, in his wheelchair. R1 appeared to reach down for an item, which caused a forward shift in weight resulting in a fall from the wheelchair, striking his face on the floor. R1 sustained a laceration to his forehead and was bleeding from his nose. R1 was transferred to the hospital and returned to the facility on [DATE], following an overnight stay. R1 had sutures to the laceration on his forehead and had mild swelling and discoloration of the nose when he returned. R1's hospital evaluation revealed an acute nasal bone fracture with no intervention required and a laceration repaired with sutures to his forehead. This report showed that Nursing and CNAs were re-educated on safe transport procedures.R1's Fall Risk assessment dated [DATE] showed he was a high fall risk.R1's Fall Risk Care Plan updated 10/8/25 showed on 10/5/25 while CNA attempting to propel wheelchair, R1 reach for supposed item off the floor and fell out of wheelchair. R1's EMR (Electronic Medical Record) did not show that R1 had refused use of footrests on his wheelchair when being propelled by staff. R1's Hospital Records dated 10/6/25 showed R1 fell out of his wheelchair and fell on his face. R1 had a nosebleed and forehead laceration that was sutured in the emergency department. R1's (CT/Computed Tomography) of his brain/cervical spine/facial bone showed he had an acute on chronic nasal bone fractures and the potential for SDH (Subdural Hematoma), therefore R1 was admitted to the Neuro ICU (Intensive Care Unit) stepdown for observation and repeat CT.On 10/9/25 at 9:28 AM, V4 (Registered Nurse - RN) said she was working 10/5/25 when R1 fell from his wheelchair. V4 said she didn't witness the fall because she was administering medications to another resident. V4 said V5 (Agency Licensed Practical Nurse - LPN) notified her of the fall. V4 said when she went to the dining room, R1 was lying on the floor bleeding from his forehead and nose. V4 said V5 had a towel on R1's forehead to stop the bleeding and V6 (CNA) was obtaining vital signs. V4 said she called 911 and R1 was sent to the hospital. V4 said R1 returned to the facility on [DATE] with a broken nose and sutures to his forehead. V4 said V6 (CNA) reported that R1 was reaching for something on the floor and fell. V4 stated, It was so strange because I've never seen him (R1) reach for anything like that. V4 said V6 (CNA) said he was going to get R1 to bed, and he fell right in front of him. I'm not sure exactly how that happened. V4 said R1 was alert and oriented and was able to make his needs known. V4 said R1 would be able to tell you what happened. V4 said R1 usually had good trunk control when he was sitting up in the wheelchair and normally asks for assistance and she was so surprised by the fall. On 10/9/25 at 10:45 AM, V5 (Agency LPN) said she was preparing meds when she heard a loud sound, as if someone fell and she heard R1 scream. V5 said she ran to the dining room and R1 was face down on the floor and V6 (CNA) was there. V5 said R1 was bleeding from his nose and forehead. V5 said she noticed R1's catheter was trapped under his leg and assumed the resident may have been trying to get the catheter out, when he fell forward. V5 said V6 (CNA) told her that R1 was reaching for