

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  06/06/2024
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39543</p> <p>Based on interview and record review the facility failed to immediately initiate potential lifesaving interventions for 1 of 1 resident (R27) reviewed for quality of care in the sample 12.</p> <p>The findings include:</p> <p>R27's Face Sheet showed a recent admitted [DATE] with diagnoses to include dysphagia (difficulty swallowing), dementia, and communication deficit.</p> <p>R27's Nursing Note from [DATE] at 3:36 PM, (note authored by V2 Director of Nursing) stated At approx. 12:30 (PM), [V6 Registered Nurse] approached this writer and asked if I could come help with [R27]. This writer asked what was going on and [V6] stated he (R27) appeared to be choking. We ran into the dining room and this writer witnessed [R27] sitting at his table with [V7 and V8 Certified Nursing Assistants] two CNAs next to him trying to get him to respond to them. Cyanosis (blue/purple color of the skin caused by lack of oxygen) could be seen on all his fingers and around his lips at first glance . The note showed, I asked if the Heimlich (abdominal thrust use to dislodge food stuck in a person's airway) had been done. [V6] responded that it had not been. [V6] started to do the Heimlich, and I went to call EMS (Emergency Medical Services). The note showed CPR (Cardiopulmonary Resuscitation) was started and an attempt to clear his airway was done. The note showed, during CPR, pureed food debris was removed from his mouth. The note showed EMS suctioned R27, placed a breathing tube, and no food was observed blocking his airway. The note showed life saving measures were unsuccessful and R27 was pronounced dead at 1:04 PM.</p> <p>R27's Nursing Note from [DATE] at 12:29 PM, (note authored by V6) stated, Called into dining room by CNA staff. Resident non-responsive making gurgling noises, spitting out some of his lunch. Went and grabbed nursing supervisor and came back. Resident brought from dining room toward nursing station. CNA staff stood resident up and this nurse attempted Heimlich maneuver. Heimlich maneuver was not effective. Nursing supervisor called 911 at this time. Resident lowered to floor and CPR was started until paramedics arrived.</p> <p>(continued on next page)</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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 2:49 PM, V6 stated I was his (R27's) nurse that day. I was sitting at nursing station charting. CNA called me over because he was not responding while eating. I noticed he was making gagging noises. So, I went down and grabbed the DON (Director of Nursing). I grabbed her and she came over and then we pulled him by the nurse's station. The Heimlich wasn't effective, so we put him on the floor and the DON called 911 and we started CPR. V6 stated V2 was in her office which was approximately 100 feet away. V6 stated, My initial instinct, when the CNA's grabbed me, was that he was choking. V6 stated he did not immediately start the Heimlich maneuver because At that moment I thought it would be better to have an extra nurse to help if he would need CPR. V6 stated, he believed R27 was sitting at the table alone and the food that was removed from R27's mouth appeared to be his pureed lunch.</p> <p>On [DATE] at 7:50 AM, V7 stated he was in the dining room with R27 during lunch on [DATE]. V7 stated R27 was able to feed himself. V7 stated he was at a table next to R27 and V8 was seated at a table across from R27. V7 stated he was first alerted to R27 having issues when he was making noises as if he was trying to clear his throat. V7 stated R27 was also not able to verbally respond, which was not normal for R27. V7 stated he could not recall who went to get V2; however, the Heimlich maneuver was not started until V2 arrived at the dining room. V7 stated he believed the amount of time from the onset of R27's issue and until the Heimlich was started was less than a minute. V7 stated, based on R27 not being able to talk, he had just been eating, and the noises R27 was making; the symptoms were consistent with choking. V7 stated he had CPR and Heimlich training.</p> <p>Multiple attempts to contact V8 CNA were made on [DATE]. V8 did not return phone calls.</p> <p>On [DATE] at 10:13 AM, V2 DON stated the Heimlich should have been started immediately upon onset of R27's symptoms. V2 stated V6 should have started the Heimlich himself and sent a CNA to get her. V2 stated, The longer you wait the worse the situation can get; time is of the essence. I was down on one of the hallways, he came to the office to get me. He (V6) stated I think [R27] is choking. V2 stated, food was removed from R27's mouth during CPR and it appeared to be his pureed lunch. V2 stated paramedics used a camera scope to insert the breathing tube and there was not food visible in his airway.</p> <p>R27's Death Certificate showed the cause of death to be Alzheimer's (dementia).</p> <p>The facility's Emergency Procedure-Choking policy (Revision ,d+[DATE]) showed, Trained staff will assist the resident who is choking by attempting to expel the foreign body from the airway .Ask the resident if he or she is choking. Remember, a choking victim cannot speak or breathe and needs your help immediately. Ask the resident to cough or speak, if at all possible, to determine if his or her airway is obstructed. If able to cough, instruct and encourage the resident to continue coughing to dislodge or expel any foreign object. Call for help but stay with the resident. Quickly assure the resident that you are going to stay and assist him or her. If the resident cannot cough, only then should abdominal thrust be performed .</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34891</p> <p>Based on observation, interview, and record review the facility failed to ensure pressure relieving interventions were in place for a resident with pressure ulcers for 1 of 4 residents (R18) reviewed for pressure in the sample of 12.</p> <p>The findings include:</p> <p>R18's undated face sheet showed an admitted [DATE] and diagnoses including but not limited to gangrene, methicillin resistant staphylococcus aureus infection, acute myeloblastic leukemia, not having achieved remission, diabetes mellitus with foot ulcer, chronic ulcer of left foot, right leg below knee amputation, elevated white blood cell count, colostomy use, and colon cancer. R18's facility assessment dated [DATE] showed no cognitive impairment and requiring staff assistance with bed mobility, transfers, toileting, and personal hygiene. The same assessment showed R18 had one or more pressure ulcers.</p> <p>R18's weekly wound round report dated 6/4/24 showed an unstageable pressure ulcer to the coccyx with current measurements at 2.5 x 2 centimeters. The report showed an unstageable right buttock pressure ulcer with current measurements at 2.5 x 2 centimeters. The report showed an unstageable left posterior ankle pressure ulcer with current measurements at 0.8 x 1 centimeters. Attached to the report was a handwritten note (unknown author) with directions: ORDER AIR MATTRESS and heel boots at all times while in bed.</p> <p>On 6/4/24 at 3:01 PM, R18 was lying in bed on a low air loss pressure ulcer mattress. R18 was thin and weak in appearance. R18 was a female resident with an almost bald head. R18 stated her buttock had been sore for days and her new air mattress has been a lifesaver. R18 stated she had just got the special air mattress and her back side was killing me before then. R18 had a nephrostomy bag and colostomy bag visible from under her gown. R18 was missing her right lower leg and her left foot was lying directly on a pillow. R18 refused to allow any observations for her buttock or coccyx wounds.</p> <p>On 6/5/24 at 9:31 AM, R18 stated she had the buttock wound when she came to the facility. Staff have been treating it daily with a cream and finally got her the special air mattress. R18 stated the wound doctor sees her every week but was unsure of which day. R18 refused any observations of her dressing changes or wounds. R18's left foot was still lying directly on a pillow.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/6/24 at 11:23 AM, V9 (Wound Care Nurse) stated she became the wound care nurse this week and just started doing wound rounds with the doctor. V9 stated R18 had an unstageable coccyx wound at admission, a right buttock wound at a stage two, a left ankle wound, and several left toes amputated. V9 stated R18 is at high risk for more skin breakdown. She eats very little, has been on chemotherapy for cancer, is refusing hospice, and is very immunocompromised. V9 reviewed R18's wound prevention orders and stated she just received a low air loss mattress just this week. It should have come in last week but didn't for some reason. V9 stated she could not say why the pressure reducing mattress was not on her bed at the time of admission. R18 needs the special mattress to relieve pressure on certain areas like her coccyx, buttocks, heel, and elbows. V9 stated the heel protector should be on whenever she is in bed. V9 stated her care plan should be reflecting the same interventions. It is important to follow the interventions, so staff know how to help her progress and heal. Without any interventions, she is at risk for her current wounds to worsen and develop new ones.</p> <p>On 6/6/24 at 11:36 AM, V2 (Director of Nurses) stated the prior assistant director of nurses was in charge of ordering pressure ulcer mattresses. V2 stated she quit abruptly last week so V2 could not say why she never ordered one for R18 at admission. V2 stated she recently realized R18 was not on the correct mattress. V2 stated the care plan should show the pressure reducing interventions needed. They help reduce pain and prevent further break down. V2 stated the interventions should be in place shortly after admission, typically within 24 hours. V2 reviewed R18's electronic medical record and said there is no care plan related to R18's wounds.</p> <p>On 6/6/24 at 11:40 AM, V10 (Care Plan/MDS minimum data set coordinator) stated residents are assessed at admission and she puts care plan interventions in place shortly after that. V10 stated they are put in resident charts the next morning if she is not here the day of admission. V10 stated the interventions are important to ensure staff know how to care for the resident. There are care plans on the door of resident rooms too. That gets updated as needed by nursing or therapy staff. V10 reviewed R18's medical record and said there should be a care plan for her pressure ulcers. The prior wound care nurse was doing care plans for skin issues, and I guess she did not do one for R18. V10 stated it should have been caught when the MDS was completed but it wasn't. It was overlooked and I guess all the care plans need to be reviewed. V10 stated she was sure there are other residents missing care plan interventions.</p> <p>The facility's Pressure Ulcers/Skin Breakdown policy revision dated 3/2014 states under the monitoring section: 2. The physician will help the staff review and modify the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions.</p> <p>R18's care plan had no focus area related to her wounds. The care plan did have one approach area start dated 10/31/23 (prior stay) related to skin concerns. The area was not completed and risks, skin condition, wounds, pressure reducing interventions were blank. The care plan on the door of R18's room was reviewed and did not show any pressure reducing interventions.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34491</p> <p>Based on observation, interview, and record review, the facility failed to ensure interventions were put in place for a resident with a history of falls, failed to ensure the resident's fall risk assessment was reassessed after a fall with injuries, and failed to develop a care plan showing he was a fall risk and identify interventions to prevent further falls for 1 of 1 resident (R11) reviewed for falls in the sample of 12.</p> <p>The findings include:</p> <p>R11's Face Sheet, provided by the facility on 6/6/24, showed he was admitted to the facility on [DATE], with diagnoses including vascular dementia with agitation, muscle wasting and atrophy, abnormalities of gait and mobility, cognitive communication deficit, anxiety disorder, bilateral ankle effusion (a buildup of fluid in the soft tissues around the ankle joint), major depressive disorder, osteoarthritis, and chronic heart failure.</p> <p>R11's care plan, with a start date of 5/16/24, showed Resident experiences wandering (moves with no rational purpose, seemingly oblivious to needs or safety). R11's care plan with a start date of 5/8/24 showed he had a memory/recall deficit.</p> <p>On 6/4/24 at 11:00 AM, R11 was observed in the dining room during the activity, sitting at a table looking around the room. R11 had an arm sleeve covering his left lower arm. R11 stated the sleeve was on his arm because he hurt his arm. When asked how he hurt his arm, R11 stated he bumped it on something.</p> <p>R11's Event Report dated 5/18/24 at 5:29 PM showed Resident found on floor in room with chair alarm sounding by CNA (Certified Nursing Assistant). Writer notified and noted resident laying on his right side on the floor with the wheelchair near his head. ROM (range of motion) checked-WNL (within normal limits). Noted 4 skin tears to left arm .Resident stated (he) was trying to walk to the bathroom and ended up on the floor . The report showed the skin tears on R11's left arm measured 5.5 cm (centimeters) x 4 cm, 1.5 cm x 1 cm, 1 cm x 1 cm, and 5.5 cm x 1 cm. The report showed the last time prior to the fall that R11 last used the bathroom or received incontinent care was at 1:30 PM (almost four hours earlier). The report also showed resident was receiving diuretics (medications that cause increased production of urine to help clear extra fluid out of the body).</p> <p>On 6/5/24 at 3:30 PM, R11 was in his room sitting in a wheelchair. The Care Plan Information sheet on R11's bathroom door did not identify R11 as a fall risk and no interventions were circled under the safety section to identify any interventions that were in place.</p> <p>R11's electronic medical record did not have a care plan showing R11 was at risk for falls and list interventions to prevent further falls.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R11's Fall Risk assessment dated [DATE] showed he was a high fall risk. The assessment showed R11 had had a fall in the six months leading up to his admission, was incontinent, had a lack of understanding of one's physical and cognitive limitations, and required assistance or supervision for mobility, transfers, or ambulation.</p> <p>On 6/6/24 at 9:05 AM, V2 (Director of Nursing-DON) stated R11 has had a fall and he is a fall risk. V2 stated R11 does have a chair alarm, but they are put on any resident with confusion or cognitive deficits. V2 stated there should have been a falls risk care plan in place for R11, with interventions in place. V2 stated a fall risk assessment was done for R11 on 5/8/24 when he was first admitted . V2 stated there has not been another one done since then. V2 stated the facility's policy is if someone has a fall, another fall risk assessment should be completed, and interventions should be put in place on their care plan.</p> <p>On 6/06/24 at 10:12 AM, V10 (MDS/Care Plan Coordinator) stated there was not a care plan in place for R11's fall risk and interventions. V10 stated it is important to make sure a risk assessment is done, and a care plan is put in place to try to prevent further falls. V10 stated R11 is a fall risk.</p> <p>R11's Physician Order Report, provided by the facility on 6/6/24, showed he was receiving skilled physical therapy to include therapeutic exercises, therapeutic activities, gait training, neuromuscular re-education, and patient education. The report showed R11 was also receiving speech therapy to address deficits in orientation, memory, problem solving, and overall cognition for safety and to prevent further regression.</p> <p>The facility's policy and procedure titled Fall Risk Assessment, with a revision date of March 2018, showed The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. The policy showed 1. Upon admission, the nursing staff and the physician will review a resident's record for a history of falls, especially falls in the last 90 days and recurrent or periodic bouts of falling over time. 2. The nursing staff will ask the resident and/or his/her family about any history of the resident falling. 3. The nursing staff, attending physician, and consultant pharmacist will review for medications or medication combinations that could relate to falls or fall risk, such as those that have side effects of dizziness, ataxia, or hypotension .5. The attending physician and nursing staff will evaluate the resident's vital signs, assess the resident for medical conditions (such as those that cause dizziness or vertigo) or sensory impairments (such as decreased vision and peripheral neuropathy) that may predispose to falls. 6. Assessment data shall be used to identify underlying medical conditions that may increase the risk of injury from falls (such as osteoporosis). 7. The staff, with the support of the attending physician, will evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, excessive motor activity, Activities of Daily Living (ADL) capabilities, activity tolerance, continence, and cognition .9. The staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences for risk factors that are not modifiable.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Falls-Clinical Protocol, with a revision date of March 2018, showed 3. The staff and practitioner will review each resident's risk factors for falling and document in the medical record .4. The physician will identify medical conditions affecting fall risk .and the risk for significant complications of falls . The protocol showed Treatment/Management: 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. The protocol showed Monitoring and Follow-Up .2. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling.</p> <p>The facility's policy and procedure titled Care Plans-Baseline, with a revision date of March 2022, showed A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality of care and must include the minimum healthcare information necessary to properly care for the resident .2. The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan (no later than 21 days after admission). The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed. 3. A comprehensive care plan may be used in place of the baseline care plan providing the comprehensive care plan is developed within 48 hours of the resident's admission and meets the requirements of a comprehensive assessment.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34891</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident with an indwelling urinary catheter had physician care orders in place for 1 of 5 residents (R25) reviewed for catheters in the sample of 12.</p> <p>The findings include:</p> <p>R25's undated face sheet showed an admitted [DATE] and diagnoses including but not limited to arthritis due to other bacteria of the left shoulder (at admission), methicillin susceptible staphylococcus aureus infection, sepsis, stage three kidney disease, prostate cancer, and retention of urine. R25's facility assessment dated [DATE] showed no cognitive impairment and the use of a urinary catheter. The same assessment showed the use of an antibiotic medication.</p> <p>R25's order history report dated 5/6/24 to 6/6/24 showed the use of intravenous cefazolin (antibiotic) from admission to 5/11/24. The same report showed an order to chart on use of the antibiotic for left should joint sepsis.</p> <p>On 6/4/24 at 2:31 PM, R25 was seated in a wheelchair in his room. R25 had a catheter bag hanging from the side of the wheelchair and dark yellow urine was in the tubing. R25 stated he was on an antibiotic when he arrived at the facility (cefazolin). R25 stated he has been weak from prostate cancer treatments and recently fell at home. The fall caused a shoulder injury that was operated on, and it became infected with a staph infection. R25 stated he came to the facility about one month ago while still on the antibiotic. The PICC line (peripherally inserted central catheter-long, thin tube inserted through a vein in the arm) was just taken out a day ago. R25 stated he has had the urinary catheter since the hospital stay and had it when he arrived at the facility.</p> <p>R25's physician order report for June 2024 was reviewed. There were no orders for the use of an indwelling catheter. R25's care plan was reviewed and there was no evidence of the use of an indwelling catheter. There were no care orders or interventions related to the urinary catheter located in R25's electronic chart.</p> <p>On 6/6/24 at 9:47 AM, V2 (Director of Nurses) stated physician orders should be in place for all residents with indwelling catheters at the time of admission. The order should include the size, when to change it, how or if it needs to be flushed, and any urology appointments coming up. V2 stated she was not sure exactly what the care plan should include but would expect the same type of information. Care interventions are needed to ensure the resident stays safe and is healing. Catheters are a common cause of urinary tract infections. V2 stated (R25) is at an even greater risk of infection based on his past medical history and recent shoulder infection. V2 reviewed R25's electronic medical record and verified there were no care orders or interventions related to the indwelling catheter.</p> <p>The facility's Urinary Catheter Care policy revision dated 9/2014 states: The purpose of the procedure is to prevent catheter-associated urinary tract infections .1. Review the resident's care plan to assess for any special needs of the resident.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Care Plans policy revision dated 3/2022 states: A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission . and must include the minimum healthcare information necessary to properly care for the resident .b. physician orders .</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>39543</p> <p>Based on interview and record review the facility failed to maintain an accurate reconciliation of controlled substances. This applies to 1 of 1 resident (R18) reviewed for controlled substances in the sample of 12.</p> <p>The findings include:</p> <p>R18's hydrocodone/acetaminophen (a combination narcotic opioid pain medication and an over-the-counter pain medication) Controlled Drug Receipt/Record/Disposition form (Controlled Substance Count Sheet) showed the order was for the medication to be given every 6 hours as needed for pain. The reconciliation form showed on 5/16/24, one tablet was dispensed, and 18 tablets remained. The next two entries on the form were lined out and error was written next to the entries. The errors were signed by only one nurse. The next entry, on 5/24/24, showed one tablet was removed and 16 tablets remained. The two stricken entries between 5/16/24 and 5/24/24 did not indicate the medication was wasted or destroyed. The form did not show an entry indicating when the 18th tablet was dispensed.</p> <p>On 6/06/24 at 12:21 PM, V2 stated, while reviewing R18's-controlled substance count sheet, V2 was unable to determine the disposition R18's 18th hydrocodone/acetaminophen tablet. V2 stated if the medication was wasted, the record should reflect this, and it should be signed by two nurses. V2 stated the two stricken entries appear to be documentation errors and not entries showing the medication was wasted. V2 stated nursing staff are expected to do a count of all controlled substances at the start/end of every shift. V2 stated if the cause of the discrepancy cannot be quickly determined and corrected; the nurses should notify herself or the Administrator. V2 stated she was not aware of this missing narcotic, and it should have been caught at shift change. V2 stated narcotic medications are more likely to be diverted. V2 stated the purpose of the count sheets is to ensure an accurate count of controlled substances and to inhibit diversion of controlled substances.</p> <p>The facility's Controlled Substances policy (Revision April 2019) showed, any wasted controlled substances should be disposed of in the presence of a witness and signed by both nurses. The policy showed, controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together. Any discrepancies in the controlled substance count are documented and reported to the Director of Nursing immediately .</p>		

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  06/06/2024
NAME OF PROVIDER OR SUPPLIER  Fair Oaks Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  471 Terra Cotta Avenue Crystal Lake, IL 60014	
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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>39543</p> <p>Based on observation, interview, and record review the facility failed to provide the correct portion of vegetables. This applies to 5 of 5 residents (R17, R21, R4, R6, &amp; R11) reviewed for menus in the sample of 12 and 3 residents (R16, R1, &amp; R80) outside the sample.</p> <p>The findings include:</p> <p>On 6/4/24 at 11:50 AM, V4 [NAME] began the noon lunch service for the dining room nearest the kitchen. V4 served sloppy joes, peas with onions, sweet potato, and cake. V4 used a green handled ice cream scoop to serve the peas and the portion appeared inadequate.</p> <p>On 6/4/24 at 12:18 PM, V4 completed the lunch service for the dining room adjacent to the kitchen. V4 stated the green handled ice cream scoop was 2.66 ounces. V4 stated the grey scoop is 4 ounces. V4 stated he always used the green scoop for vegetables.</p> <p>The facility's menu and recipe for peas showed the portion size should be 4 ounces.</p> <p>On 6/05/24 at 9:54 AM, V3 Dietary Manager stated the residents in the dining room adjacent to the kitchen only received 2 and 2/3 ounce of peas and they should have been served 4 ounces. (More than a 30 percent deficit.) V3 stated, The dietitian reviews the menu, and the portions are sized to ensure the residents receives the correct amount of nutrition and nutrients for a healthy diet and healing.</p> <p>The facility provided list of residents who dined in the dining room adjacent to the kitchen, and were a regular diet, included R16, R1, R17, R21, R4, R11, R6, and R80.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>39543</p> <p>Based on observation, interview, and record review the facility failed to measure food temperature on the steam table in a manner to prevent cross-contamination. This applies to 5 of 5 residents (R17, R21, R4, R6, &amp; R11) reviewed for menus in the sample of 12 and 3 residents (R16, R1, &amp; R80) outside the sample.</p> <p>The findings include:</p> <p>On 6/4/24 at 11:50 AM, V4 began the lunch service for the dining room adjacent to the kitchen. V4 stated he had already measured the temperature of the sloppy joe meat; however, it was requested he check the temperature again. V4 removed a thermometer from a cup that contained numerous writing utensils. V4 then stuck the thermometer probe into the sloppy joe meat without sanitizing the thermometer. V4 then continued with the lunch service.</p> <p>On 6/05/24 at 9:54 AM, V3 Dietary Manger stated .He (V4) should have cleaned the thermometer then temped the sloppy joe. The purpose of cleaning the thermometer first is to prevent any cross contamination to make sure it's clean before it goes in the food and to make sure there is no debris from its previous use.</p> <p>The facility provided list of residents who dined in the dining room adjacent to the kitchen, and were a regular diet, included R16, R1, R17, R21, R4, R11, R6, and R80.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34491</p> <p>Based on observation, interview, and record review, the facility failed to prevent cross-contamination when assisting a resident with their toileting needs, and failed to ensure staff wore the proper PPE (personal protective equipment) while providing direct care to a resident on enhanced-barrier precautions for 1 of 2 residents (R18) reviewed for infection control in the sample of 12, and 1 resident (R83) outside the sample.</p> <p>The findings include:</p> <p>1. R83's Face Sheet, provided by the facility on 6/6/24, showed she had diagnoses including displaced fracture of upper end of the left humerus (the long bone that extends from the shoulder to the elbow), osteoarthritis, obesity, and glaucoma. R83's facility assessment dated [DATE] showed she is dependent on staff for toileting and lower body dressing and requires substantial/maximal assist with upper body dressing and getting on and off the toilet.</p> <p>On 6/4/24 at 1:46 PM, V15 (Certified Nursing Assistant-CNA) was assisting R83 with her toileting needs. R83 had a bowel movement. V15 wiped the stool from R83, then folded the toilet paper, using only her left gloved-hand, and wiped again. V15 repeated this process two more times, then wiped the stool from the toilet seat with toilet paper. V15 left the same gloves on used to clean R83's stool to pull R83's brief and pants up. V15 pulled R83's shirt down and readjusted the gait belt around R83. V15 touched the gait belt in several areas while walking R83 back to her wheelchair. V15 touched both brakes on the wheelchair with her left gloved-hand and the left handle on the wheelchair before removing the soiled glove and washing her hands.</p> <p>On 6/6/24 at 9:32 AM, V2 (Director of Nursing-DON) stated after cleaning a resident who had a bowel movement, she would expect the CNA to remove the gloves, wash or sanitize her hands and put clean gloves on, before touching the resident or anything in the environment to prevent cross-contamination.</p> <p>R83's skin integrity care plan, with a start date of 6/6/24 (last day of survey) showed R83 has the potential for further skin breakdown related to impaired mobility. The care plan showed Assist with toileting.</p> <p>The facility's policy and procedure titled Personal Protective Equipment-Glove Use, with a revision date of September 2010, showed When to Use Gloves: 1. When touching excretions, secretions, blood, body fluids, mucous membranes or non-intact skin .3. When cleaning up spills or splashes of blood or body fluids.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's policy and procedure titled Handwashing/Hand Hygiene, with a revision date of August 2019, showed The facility considers hand hygiene the primary means to prevent the spread of infection .1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations .h. Before moving from a contaminated body site to a clean body site during resident care .j. After contact with blood or bodily fluids .m. After removing gloves .9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. 10. Single-use disposable gloves should be used .b. When anticipating contact with blood or body fluids .</p> <p>34891</p> <p>2. R18's undated face sheet showed an admitted [DATE] and diagnoses including but not limited to gangrene, methicillin resistant staphylococcus aureus infection, acute myeloblastic leukemia, not having achieved remission, diabetes mellitus with foot ulcer, chronic ulcer of left foot, right leg below knee amputation, elevated white blood cell count, colostomy use, and colon cancer. R18's facility assessment dated [DATE] showed no cognitive impairment and requiring staff assistance with bed mobility, transfers, toileting, and personal hygiene. The same assessment showed R18 had one or more pressure ulcers.</p> <p>On 6/4/24 at 2:56 PM, V11 (Physical Therapist) and V12 (Director of Physical Therapy) transferred R18 using a slide board from the bed to a wheelchair in her room. V11 and V12 wore gloves but did not have gowns on. R18's nephrostomy and colostomy bags were visible from under her shirt. V12 stated they were just about to do a second transfer from the wheelchair to the upright recliner. R18 requested to rest for a minute. V11 and V12 stated they would return shortly and continue with the transfer. R18 requested this surveyor return later for any interviewing. This surveyor exited R18's room and noted the signage on the door clearly stating R18 was on enhanced barrier precautions. The sign showed staff must wear gloves and a gown for high-contact resident care activities. Those care activities were listed and included: transferring, the use of invasive tubing devices, and the presence of wounds. A stocked bin of PPE (Personal Protective Equipment) was next to the doorway.</p> <p>On 6/4/24 at 3:12 PM, V11 and V12 donned gloves outside of R18's room and closed the door to do the second transfer. V11 and V12 did not don a gown prior to entering the room.</p> <p>On 6/4/24 at 11:06 AM, V13 (Registered Nurse) stated the facility policy states PPE is needed in enhanced barrier precaution rooms if care is being provided. A gown and gloves are necessary anytime staff are providing any of the care activities shown on the isolation precaution door sign.</p> <p>On 6/6/24 at 9:39 AM, V2 (Director of Nurses) stated enhance barrier precautions are put in place for residents with wounds, catheters, ostomies, feeding tubes and such. The gown and gloves are an extra precaution to protect the resident from outside germs getting introduced into the open areas of the body. All staff need gowns and gloves during care. April 1st was our big day and we started requiring the PPE then. That includes the therapists too. Only wearing gloves is not enough. Gowns are required too to reduce the risk of infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Enhanced Barrier Precautions policy revision dated 12/19/22 states: Enhanced Barrier Precautions are defined as the use of PPE (gowns and gloves) during high-contact resident care activities that generate opportunities for transfer of MDROs in the form of blood or body fluids, onto the hands and/or clothing of the rendering caregivers.</p>		