FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ C B. WING IL6002984 02/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1515 BLACKHAWK BOULEVARD FAIR OAKS REHAB & HEALTHCARE SOUTH BELOIT, IL 61080 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S 000 **Initial Comments** S 000 Complaint Investigation #2110738/IL130684 S9999 Final Observations S9999 Statement of Licensure Violations: 300.1210 b) 300.3240 a) Section 300.1210 General Requirements for Nursing and Personal Care The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

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of time. These failures also resulted in R1 not receiving a nursing assessment and experiencing

neglect a resident.

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Section 300.3240 Abuse and Neglect

An owner, licensee, administrator, employee or agent of a facility shall not abuse or

These regulations are not met as evidenced by:

Based on interview and record review, the facility failed to provide pain management to a resident (R1), failed to provide nursing services to a resident (R1), and failed to ensure a resident (R1) was free from social isolation. These failures resulted in R1 experiencing prolonged pain without medication intervention, and being isolated in a shower room for an extended period

TITLE

Attachment A

Statement of Licensure Violations

(X6) DATE

PRINTED: 03/09/2021 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING IL6002984 02/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1515 BLACKHAWK BOULEVARD FAIR OAKS REHAB & HEALTHCARE SOUTH BELOIT, IL 61080 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE **TAG** TAG **DEFICIENCY**) S9999 Continued From page 1 S9999 emotional instability. The findings include: The facility's admission and discharge log, printed on 2/5/21, showed R1 was admitted to the facility on 2/1/21 and discharged from the facility on 2/1/21. Areview of R1's electronic medical record showed no diagnosis, medication, progress notes, care plan or assessments were entered for R1 during his time at the facility from 2/1/21 at 2:30PM thru 2/1/21 at 7:30PM. On 2/9/21 at 9:24AM, V8 (Registered Nurse) stated, "(R1's) admission was awful. He was an anticipated admission coming from a local facility to be closer to his family. He came to the building and I told (V9-Certified Nursing Assistant, CNA) to complete her part of his admission. (V9) then alerted me that (R1) had bed bugs. I notified (V2 Director of Nursing) and she went to (R1's) room. (V2) told me that (R1) could not stay in the facility. R1's roommate was then moved to an alternate room (creating a private room for R1). R1 was then taken to the shower room and kept in there until we were able to get him transported to the hospital. We had to attempt to feed him dinner in the shower room because his room had been sprayed for bed bugs and we didn't have

resident." Illinois Department of Public Health

anywhere else to put him because of COVID restrictions. (R1) arrived at the facility between 2:30PM-3:00PM and the transportation company

6:30PM-7:30PM. (R1) received a change of clothes but I could not provide any nursing services to him or chart anything in his records because I was told by (V2) that he was not our

finally arrived somewhere between

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED			
	<u></u>	IL6002984	B. WING		C 02/09/2021			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE				
FAIR OA	FAIR OAKS REHAB & HEALTHCARE 1515 BLACKHAWK BOULEVARD SOUTH BELOIT, IL 61080							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE		
S9999	Continued From page 2		S9999					
	came to the facility around 2:30PM-3:00 and transferred him stood him up I saw We gave (R1) a me and propped the do dinner because he hand swearing and to bugs into the facility there wasn't anything	M, V9 (CNA) stated, "(R1) at the beginning of my shift OPM. We took him to his room into a recliner. When we bugs crawling on his back. Fall tray in the shower room or open. He wouldn't eat was so upset and kept yelling celling us he didn't bring the r. I felt so bad for him because ag I could do for him. We didn't until right before he left for the						
	stated, "(R1) arrived around 3PM. (V9) chad beg bugs on hir room to put (R1) in. bagged up his belor The next thing I kneemergency room for surprise me becaust think he left the facil He wasn't with us loprovided to him. We admission so no me His room was to be inspected for further as the room is clear back into the room. cleared the room that he recliner (R1) was documentation in (R the nurse on duty diservices because he	R1's) medical record because d not perform any nursing e wasn't our resident."						
		M, V10 (R1's power of y brother called me from the						

(X3) DATE SURVEY

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETE	D		
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FAIR 0A	FAIR OAKS REHAB & HEALTHCARE 1515 BLACKHAWK BOULEVARD SOUTH BELOIT, IL 61080							
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S9999	Continued From pa	ge 3	S9999					
**************************************	couldn't stay at the him up because he very upset about thi being up in a wheel was so confused at angry that the local in just to calm him osituation. When my room there were no (V7) told me that the at the facility for my sat in the emergence waiting for alternation.	M, V7 (Community Relations		nii ≅				
	called his primary p the local emergency refused to have (R1 came from. I greete 2:30PM and he was wheelchair then the room, and removed from the facility. (R1 no meals were prov	, "I think (V10-R1's daughter) hysician and had him sent to y room for back pain. (V10)) sent back to the facility he of (R1) in his room around a checked in, transferred to his staff took him to the shower his clothes and belongings I) was offered hydration but rided to him. I left to go home t because I thought everything		0.998.53				
	"(R1) had bugs and	M, V1 (Administrator) stated, bites all over his body. I get it m but we did not have a hit him to."	:2					
	showed, "(R1) was closer to family on 2 admitted and perso patient stating he ha	local hospital, dated 2/1/21, transferred to a facility to be 2/1/21. He was never actually nnel there refused to take the ad bedbugs. On evaluation of bedbugs. It is very difficult				=		

(X2) MULTIPLE CONSTRUCTION

Illinois Department of Public Health

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
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	IL6002984		B. WING	B. WING		02/09/2021	
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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S9999	Continued From page 4		S9999				
	to accurately reconcile his medications with our limited information."						
				0			
		local hospital, dated 2/1/21, es his primary concern is his					
		e states is constant and					
		sfer and is primarily located to					
	his lumbar spine. Denies itchiness, no new rashes. Skin warm and no clearly visualized bite						
		marks on initial examination."					
	Dilla alcotronia mad	lical report at the facility					
	R1's electronic medical record at the facility showed no skin assessment or medication						
	administration for 2						
				3):		55	
	(B)				120		
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Illinois Department of Public Health STATE FORM

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