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 02/08/2022 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 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE **TAG** DEFICIENCY) S 000 **Initial Comments** S 000 Facility Reported Incident of January 20, 2022 IL143216 S9999 Final Observations S9999 Statement of Licensure Violations: 300,610 a) 300.1210 b) 300.1210 d)6) Section 300.610 Resident Care Policies The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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 Attachment A care needs of the resident. Statement of Licensure Violations Pursuant to subsection (a), general

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ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	Continued From page 2		S9999				
	R1's Fall Risk Assessment, completed 1/20/22, showed R1 was a "High Risk" for falls.						
	R1's Progress Note, dated 1/20/22 at 10:51 AM, showed "Resident walking with therapy at 0920. Heard the sound of a fall. Therapist stated that she just fell over and did not hit her head. Resident complaining of pain in left hip and stated that she thinks it is broken"						
	showed R1 was at r	Plan, revised on 1/21/22, isk for falls and a gait belt all walking activities and		isg			
	showed, "R1 was a Certified Occupati (COTA). She becam floor, landing on her assessment, her left the other and rotated complained of pain emergency room at evaluation and treated a left hip fracture Owitnessed fall during with therapist. R1 ha	. R1 was sent to the					
	fall), showed R1 had impairment; was total	ally dependent on 2 or more d not walk in the corridor; and			v		
	walking with R1 whe	M, V4 (COTA) said V4 was n R1 fell (1/20/22). V4 said own the hall, back to R1's	:				

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should be using a gait belt on R1.

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\$9999	showed, "Policy Sta promote patient saf activities especially and balance activiti during any treatmer patient at risk. Ther	atement: Gait belts are used to fety during treatment related during transfer, ambulation, es. Gait belts should be used at activity that may place a apist must be within close to reach the gait belt to assist		DEFICIENCY									
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