STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002984	A. BUILDING: _____ B. WING _____	C 08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
S 000	Initial Comments Incident Report Investigation to Incident of August 14, 2017/IL 96243	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)2) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) 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 b) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002984	A. BUILDING _____ B. WING _____	C 08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 1	S9999		

care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

2) All treatments and procedures shall be administered as ordered by the physician.

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002984	A. BUILDING: _____ B. WING _____	C 08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements were not met as evidenced by: Based on interview, and record review the facility failed to ensure a resident at risk for choking, did not have access to and did not consume nectar consistency liquids. These failures contributed to R1 being given nectar consistency liquids and aspirating on August 14, 2017. R1 expired on August 15, 2017. This applies to 1 of 3 residents (R1) reviewed for risk of choking in a sample of 8. The findings include: During this survey, R1 was unavailable for observation or interview. R1's Progress Note dated August 15, 2017, showed R1 expired at 11:15 AM. R1's Hospice Patient Information Sheet dated February 12, 2016 showed R1's primary hospice medical diagnosis as dysphagia. R1's Care Plan dated August 21, 2017, showed R1 had a history of aspiration pneumonia, was under the care of a local hospice service, and required a pureed diet with honey thick liquids. On August 21, 2017 at 10:00 AM, E6 CNA stated that she assisted R1 with eating dinner on the evening of August 14, 2017. E6 CNA stated,	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002984	A. BUILDING: _____ B. WING _____	C 08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 3	S9999		

"(R1) had pretty much finished his dinner of pureed spaghetti with no episodes of choking. He also had a thickened drink that was red, it looked like fruit juice. A plastic cup of Med Pass (nutritional supplement) was right next to (R1's) fruit juice on the table. I handed the cup of nutritional supplement to (R1) and he took a drink. He started choking right away after he took a drink . We got the nurse right away and she did the Heimlich maneuver on (R1). A white substance started coming out of (R1's) mouth. I don't know where the nutritional supplement came from. I just assumed it (nutritional supplement) was (R1's) because it was right next to his plate and fruit drink. I didn't know at the time that the nutritional supplement wasn't honey thickened consistency."

On August 21, 2017 at 10:30 AM, E2 Director of Nursing (DON) stated that she received a call from E4 Licensed Practical Nurse (LPN) on the evening of August 14, 2017 stating that R1 had a choking episode at dinner. E2 DON stated, "(R1) did not have a physician order for Med Pass (nutritional supplement). That nutritional supplement is nectar thick consistency, not honey thick consistency . I have no idea who put the nutritional supplement on (R1's) table. The nurses administer the nutritional supplements to residents. Nutritional supplements should never be left for a resident to finish. The nurse is to wait and watch as the resident consumes the supplement. I also just inserviced the CNA's (including E6) on checking the residents' diet tickets for food and fluid consistency prior to serving the residents." E2 also stated she had interviewed numerous staff in an attempt to find out where the nutritional supplement had come from on the evening of August 14, 2017. E2 stated that all of the staff interviewed denied any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002984	A. BUILDING: _____ B. WING _____	C 08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 4	S9999		

knowledge of where the nutritional supplement had come from.

On August 23, 2017 at 3:30 PM, E10 (Food Service Director) stated, "The difference between honey thick fluids and nectar thick fluids is the consistency. Honey thick fluids are thicker in consistency than nectar thick fluids."
The label on the container (undated) of the nutritional supplement used by the facility showed, "Suitable for nectar consistency diets."

On August 21, 2017 at 12:15 PM, E4 LPN stated, "I put the Med Pass (nutritional supplement) on the table that evening by the spot where (R2) sat. (R2) sat next to (R1) in the dining room. (R1) must have gotten a hold of (R2's) nutritional supplement . I handed the nutritional supplement to (R2) in the dining room and left it with him. I can't really verify if (R2) drank any of his nutritional supplement. I was called into the dining room that evening (August 14) by staff because (R1) was choking. I gave him the Heimlich and he coughed up a milky substance. We immediately wheeled him to the nurse's station and put him on oxygen. I could hear audible rattles coming from (R1's) lungs." E4 stated she called the hospice nurse and physician immediately after the event.

On August 23, 2017 at 1:45 PM, E1 (Administrator) denied that R1 had any history of reaching for food on the table or taking food from other resident's plates. E1 stated that R1 needed assistance to eat.

On August 21, 2017 at 11:05 AM, Z1 (Hospice Nurse) stated that the on-call hospice nurse notified R1's son at 7:31 PM on August 14, 2017 of R1's choking episode and the son did not want

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002984	A. BUILDING: _____ B. WING _____	C 08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 5	S9999		

R1 sent to the hospital. Z1 said she updated R1's son at 11:00 AM on August 15, 2017 on R1's condition and the son stated again that he did not want R1 sent to the hospital . Z1 stated, "R1's official diagnosis for hospice was dysphagia. R1 became hospice in February 2016. Over the last six months, he had been on increased aspiration precautions due to two episodes of aspiration pneumonia. The last two times he was treated for aspiration pneumonia with antibiotics was September 14, 2016 and October 2, 2016. He had an order for a pureed diet with honey thick liquids. He has never had an order for Med Pass (nutritional supplement). Med Pass is not honey thick. We expected him to pass from something related to his dysphagia ."

On August 23, 2017 at 1:50 PM, Z2 (Hospice Physician) stated he was notified that R1 had a choking episode on the evening of August 14, 2017 by the on-call hospice nurse. Z2 stated, "I don't recall being told that (R1) had received the wrong fluids. (R1) had been on increased aspiration precautions such as sitting up-right in the chair in the dining room and the pureed diet. I believe (R1's) cause of death was aspiration but I would have to check."

R1's Care Plan, Minimum Data Set (MDS), Physician Orders, Progress Notes, Hospice Notes, Incident Report (dated August 15, 2017), and Comprehensive Diet Assessments were reviewed. R1's Physician Order Summary dated February 17, 2016 showed "Regular diet, Pureed texture, Honey thick Fluids." No order for a nutritional supplement (Med Pass) was found in R1's Physician Order Summary. R1's MDS dated July 24, 2017 showed that R1 required the extensive assistance of one staff to eat.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002984	A. BUILDING: _____ B. WING _____	C 08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 6 The facility's Resident Nutrition Services Policy dated April 2010 showed, "3. Prior to serving the food tray, the Nurse Aide/Feeding Assistant must check the tray card to ensure that the correct food tray is being served to the resident. If there is doubt, the Nurse Supervisor will check the written physician's order." (A)	S9999		