PRINTED: 05/17/2018

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 04/11/2018 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 ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG DEFICIENCY) S 000 Initial Comments S 000 Complaint # 1812167/IL101574 \$9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.690b)c) 300.1010h)i) 300.1210b) 300.1210d)3)6) 300.3240a)b)d) 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 Attachment A Section 300.690 Incidents and Accidents The facility shall notify the Department of Statement of Licensure Violations any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a

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resident.

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

TITLE

(X6) DATE 05/04/18

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b)

A facility employee or agent who becomes

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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FAIR OAKS REHAB & HEALTHCARE 1515 BLACKHAWK BOULEVARD SOUTH BELOIT, IL 61080						
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	On April 5, 2018 at 2018 10:00 PM-6:00 we take vital signs at the fall, notify family neurological checks with in the shift." V4 morning about 3:30 what day. V4 said "in to work for me abtell her about R1's foreport and I did not stayed to finish. I do medical doctor or famedical docto	2:42 PM, V4 (worked March 8, 0 AM) said, "If a resident falls, and document it. We report and doctor, and perform a. It should be documented asaid R1 fell early in the AM, but could not remember V5 Wound Care Nurse came bout 4:00 AM. V5 said I did not all. I forgot to fill out a fall do vital signs. I should have on't remember if V5 called the family. I did not call the simily. I was off the weekend ccurence report a few days				
	Nursing) said if a re skin assessment, no notify the doctor and documented in the p Charting should be There were no neur	orogress notes/nurse notes. done during that shift. ological checks documented.				
	fall until March 10, 2	signs documented after R1's 2018.				
	9, 2018 shows V5 p	rse's Time Card dated March unched in at 4:50 AM to hed out nine minutes later at				
The state of the s	Nurse (Worked Mar PM) said she asked assess R1 because complained of pain of reach for his own was	1:15 PM, V5 Wound Care ch 9, 2018 6:00 AM-10:00 V13 Medical Doctor to he was acting strange. R1 everywhere. R1 could not ater. R1 was kept in bed that se his call light and he				

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"patients presents with left ribcage bruising for the

past two days. Patient states he fell in the bathroom though his facility states they were

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on March 8, 2018.

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went on." V5 assessed R1's skin and their were scattered bruises on his side that were purple.

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R1's Health Status Note dated March 10, 2018 at 4:00 AM shows V12 entered a note that says, "R1 awake, complains of pain in back and left rib area, with coughing. Medicated for pain."

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