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 03/11/2022

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 Complaint Investigations 2211973/IL144571 and 2211972/IL144559	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610 a) 300.1210 b) 300.3240 a) 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 care and personal care shall be provided to each resident to meet the total nursing and personal	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 03/11/2022

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 care needs of the resident. 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 are not met as evidenced by: Based on observation, interview, and record review, the facility failed to protect a resident from sexual and physical abuse. This applies to one of three residents (R1) reviewed for abuse in the sample of 8. This failure resulted in R1 being sexually abused on 12/25/21 by a family member and physically abused by a staff member on 3/6/2022. R1 remains fearful the male nurse will return to R1's room and is combative with care. The findings include: The facility face sheet for R1 shows R1 was admitted to the facility on 9/17/2021, with diagnosis to include cerebral vascular accident, hemiplegia of the left side of her body, and multiple pressure ulcers. The facility assessment, dated 12/1/2021, shows R1 to have moderate cognitive impairment and R1 is dependent on 1-2 staff for activities of daily living. 1.On 3/9/2022 at 10:15 AM, R1 could be heard behind a closed-door yelling "stop it, leave me alone, get out of here, don't touch me, don't touch my leg". V1, Administrator, was present with the surveyor outside the door and said R1 has experienced sexual abuse from R1's son in December. V1 said R1 has these behaviors of yelling out with any care R1 receives from staff. Observation of the care showed the resident pleading for help for the staff to leave R1 alone,	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 03/11/2022

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 and to stop being touched. (R1 was being assisted to R1's wheelchair to go see the dentist) On 3/10/2022 at 9:00 AM, V1 and V3, Social Service Director, said there was an incident on 12/25/2021, in which R1 was receiving a visit from R1's son, V14. V14 was observed leaning over R1 fondling her breasts and open mouth kissing R1. V1 said the Certified Nursing Assistant (CNA) who witnessed this happening immediately got the nurse, and V14 was escorted out of the building. On 3/10/2022 at 9:45 AM, V6, CNA, said V6 was working on 12/25/2021, and was in the hall near R1's room and V6 saw V4, CNA, in the hall outside R1's room. V6 said V4 was visibly shaken, and told V6 V4 had just seen V14 kissing R1 on the mouth. V6 said V6 went to get the nurse, and the nurse came to the room and told V14 he had to leave the facility. On 3/10/2022 at 11:00 AM, V4, CNA, said V4 answered R1's call light on 12/25/2021, and observed a man visiting with R1. R1 was on the phone, and the man told her they were fine. V4 said V4 shut off the light, but remained in the hall because V4 had a weird feeling about him. V4 said soon after, the call light came on again and V4 entered R1's room, and found V14 with V14's hands under R1's shirt, fondling R1's breast, and V14's "tongue down (R1's) throat". V4 said V4 entered the room and said, "excuse me", and V14 immediately stood up and almost fell to the floor. V4 said V4 asked R1 if R1 was OK, and R1 said yes. V4 said V4 stayed in the doorway, but looked around in the halls for help. V4 yelled for the nurse, but the nurse was with another resident. V4 then saw V6, CNA, and told V6 what V4 saw, and told her to get some help. V4 said	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 03/11/2022

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 V4 did not know V14 was R1's son, but the "look on (R1's) face made me feel like something was wrong". V4 said V14 appeared drunk. On 3/10/2022 at 2:00 PM, V5, Registered Nurse (RN), said V5 was the nurse working that night. V5 said V5 was notified of the incident by V6, and went directly to R1's room and told V14 he "had to leave now." V5 said V14 appeared drunk, and V14's shirt was undone. V5 said after V14 left the facility, V5 made sure R1 was OK, and then V5 called the Administrator and the Director of Nursing (DON). V5 said R1 was assessed, and later sent to the emergency room for an examination. V5 said the police came to the facility to talk to the staff and the resident. V5 said, "(R1) has always had behaviors of yelling when we provide care and now, I know why." On 3/10/2022 at 12:10 PM, V2, DON, said R1's POA was notified of the sexual abuse witnessed by staff, and that the police had been called. V2 said V2 told the POA R1 was being sent to the emergency room to be examined as the police had instructed them to do. 2. On 3/9/2022 at 8:40 AM, V1 and V2, DON, said on 3/6/2022, R1 was being transferred into bed by V10, Registered Nurse/RN, V11, CNA, and V7, Nursing Assistant (NA), and R1's catheter was accidently pulled out. V1 and V2 said they were notified by facility staff that physical abuse had happened during this transfer, and with the replacement of the foley catheter. V2 said the abuse was reported to V6, CNA, by V7, and V6 reported to V2. V1 said V1 received a call from V10 stating R1's foley catheter had been pulled out accidently.	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 03/11/2022

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 On 3/9/2022 at 9:00 AM, R1 said V10 was rough with R1 on Sunday night (3/6/2022). R1 said V10 slapped R1's arm and put the catheter up in R1's face and was waving it around. "He was yelling at me. If he ever comes in my room again, I feel like I would have to protect myself from him. I'd hit him". On 3/9/2022 at 9:15 AM, V6, CNA, said V6 received a call from V7 telling V6 that V7 had been helping with the transfer of R1 with V10 and V11. V6 said V10 was rough with R1, and was rushing the care. V6 said she was told by V11 that V10 had slapped R1 and was flapping the foley catheter in R1's face. V6 said she called V1 right away. On 3/9/2022 at 9:40 AM, V7 said V7 was in the room helping with the transfer with R1. V7 said R1 was yelling at the staff saying, "Don't touch me" and V10 was yelling back at R1. V7 said as the transfer was happening, the catheter bag fell to the floor. V7 said V7 told V10 the bag fell to the floor, and V10 told V7 to just get R1 in the bed. As R1 was being turned to the bed, V10 stepped on R1's catheter bag. As the lift moved, the catheter was pulled out of R1 as R1 was lowered into the bed. V7 said V7 then turned V7's back and was helping R1's roommate get ready for bed, but V7 heard continued yelling to R1 from V10. V7 said V7 was told by V11 that V10 had slapped R1's arm and waved the catheter in R1's face. On 10/9/2022 at 10:20 AM, R1 was being assisted out of her bed to go see the dentist. R1 was struggling with the staff and yelling at them to stop touching her, don't touch my foot, don't touch me and "not that black guy" (Meaning the male nurse V10).	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 03/11/2022

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 On 3/9/2022 at 1:20 PM, V10 said V10 would never slap a resident; V10 was reinserting the catheter, and R1 was trying to grab V10's hands, so V10 pushed R1's hands away. V10 said V10 did not wave or put the foley catheter in R1's mouth or R1's face. V10 said V10 called V1 in case there were complaints from the residents that medications were late. On 3/9/2022 at 1:50 PM, V11, CNA, said during the transfer of R1 back to bed, the process was rushed, and V10 was pushing and pulling roughly on R1 during the transfer. V11 said as V10 was reinserting the catheter, R1 was yelling out stop don't touch me. V10 took the rubber end of the catheter and flipped it towards R1's face and said to R1 repeatedly, "Shut up, why are you screaming". V10 then purposefully slapped R1's arm as R1 was trying to grab V10's arm. V11 said V11 took hold of R1's hands while the catheter was being put back into place, because she was afraid V10 would hurt R1. V11 said R1 was screaming out the whole time that R1 was in pain and to stop touching R1. On 3/10/2022 at 2:15 PM, V1 said after the incident on 12/25/2021, the staff were educated on abuse including reporting, protecting the resident, and the types of abuse. V1 said after this incident, R1 has been offered and is receiving services with a social worker. V1 said V1 did not feel V1 could educate the staff on caring for a victim of sexual assault without announcing R1 was sexually abused. V1 said R1's behaviors could be because of the abuse R1 has suffered in the past. V1 said since the incident on 12/25/2021 they have been learning more of R1's past.	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 03/11/2022

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 care plan, with a revision date of 12/28/2021, for risk of decline in mood related to experiencing sexual abuse shows an intervention, dated 9/21/2021, for behaviors of scream/yelling out during cares, but no interventions on how to care for the resident while having these behaviors. There was no care plan for risk of abuse for a resident with behaviors related to care behaviors. The social services history and comprehensive assessment, dated 9/17/2021, shows R1 answered "yes" to the question willing to answer questions regarding certain traumatic events, and denied a history of sexual assault. The same assessment shows behaviors of screaming and verbally threatening others, screaming at others, and cursing at others daily. The facility policy for abuse, with a revision date of 1/2017, shows, "Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians' friends or other individuals." (A) 2 of 2 300.610 a) 300.1210 b) 300.1210 d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and	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 03/11/2022

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 7 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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: 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. These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to safely transfer a	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 03/11/2022

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 8	S9999		

resident. This applies to one of three residents (R2) reviewed for transfers in the sample of 8. This failure resulted in R2 having extensive bruising to R2's breasts, under arms, to R2's back. R2 also had pain and a decrease in range of motion.

The findings include:

On 3/9/2022 at 10:45AM, R2 said two staff members put the gait belt around R2's breasts to transfer R2 to the bed. R2 said R2 told the staff the belt was too high on R2's chest and should be around R2's abdomen. R2 said the staff told R2 that was the only way they knew how to put the gait belt on. R2 said as R2 was being assisted into R2's bed, R2 screamed out in pain because it hurt so bad. R2 showed the surveyor R2's bruising. Both breasts were black and blue, as well under R2's left arm and onto R2's left back. R2 said they were very swollen at first, and looked like two big bowling balls. R2 said it was hard to move R2's arms due to the pain, and R2 was afraid of falling because R2 wasn't sure how they would get R2 up. R2 said R2 could not remember when it happened, or who the staff were that did it.

On 3/9/2022 at 12:00 PM, V2, Director of Nursing (DON), said the bruising was first brought to V2's attention on Monday 3/7/2022, by the therapy department. V2 said it was very apparent the bruising was caused by improper placement of a gait belt. V2 said V2 was unsure of when it happened and who was responsible for the transfer. V2 said a gait belt should be applied around the abdomen and not the chest.

On 3/9/2022 at 12:10 PM, V7, Nursing Assistant (NA), said V7 was helping R2 get dressed for bed

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 03/11/2022

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 9 on Sunday night, 3/6/2022, and noticed the bruising to R2's breasts. V7 said V7 did not tell anyone because V7 figured someone already knew about it. On 3/9/2022 at 1:50 PM, V11, Certified Nursing Assistant (CNA), said V11 first noticed the bruises to R2's chest and back on Wednesday, 3/2/2022. V11 said V11 did not tell anyone because V11 figured the nurses already know about it. V11 said R2 was having a hard time moving R2's arms. On 3/10/2022 at 10:55 AM, V12, Occupational Therapy Assistant (OTA), said V12 was working with R2 on 3/4/2022, and R2 was having a hard time moving R2's arms. V12 said when V12 asked R2 if R2 was in pain, V2 showed V12 the bruising to R2's breasts, arm, and back. V12 said V12 had to stop therapy that day because of the pain. V12 said V12 went and told the DON right away about the bruising. The OTA progress note, dated 3/4/2022, shows R2 complained of an increase in pain to R2's left side and breast area. V12 also documented the nurse was informed. The nursing progress note, dated 3/7/2022 by V2, shows R2 has purple bruising to R2's bilateral breasts, left upper inside arm and left side of R2's back. Brusing is consistent with improper placement of gait belt during a transfer. R2 changed to a mechanical left transfer. The facility face sheet shows R2 has diagnosis to include muscle weakness, difficulty in walking and COVID-19. The facility assessment, dated 1/27/2022, shows R2 requires extensive assistance of two staff for transfers. R2's skin	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 03/11/2022

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 10 check, dated 3/8/2022, shows bruising to left and right breasts and under bilateral arms. The facility policy, reviewed on 9/28/2020, for gait belts shows, Gait belts are used to promote safety during treatment related to activities especially during transfer... Gait belts should be secured around the residents trunk with care to preserved skin integrity.... (B)	S9999		