STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED
	IL6011803	B. WING	06/12/2023

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PEARL OF CRYSTAL LAKE, THE

1000 EAST BRIGHTON LANE CRYSTAL LAKE, IL 60012

	CRYSTAL	LAKE, IL 6	0012	
(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	S 000	i i	-
2	Annual Licensure Survey	.= 1		
S9999	Final Observations	S9999		
	Statement of Licensure Findings:			
	1 of 3			
W:	300.610a) 300.1210b)3) 300.1210b)4)	5	n, 95	
	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		* 2	M
	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.		2 3	
	Section 300.1210 General Requirements for Nursing and Personal Care		22	
	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		% [⊗]	2.
	plan. Adequate and properly supervised nursing care and personal care shall be provided to each		Attachment A Statement of Licensure Violations	

Illinois Department of Public Health

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

TITLE

(X6) DATE

	Chairment of Lapuc	r içaili i				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			B. WING			
		IL6011803	B. WING		06/1	2/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
1000 FA			T BRIGHTO	N LANE		
PEARL	OF CRYSTAL LAKE, T	HE	LAKE, IL 60			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 1	S9999			
	resident to meet the	e total nursing and personal				
	Sale Hoods of the f					
		nnel shall assist and				
		ts so that a resident who is all and/or bladder receives the				
		ent and services to prevent				
	urinary tract infection	ons and to restore as much				
		ction as possible. All nursing sist residents so that a resident				
		lity without an indwelling				
	catheter is not cath	eterized unless the resident's				
	clinical condition de					
	catheterization was	necessary.				
		onnel shall assist and				
		ts so that a resident's abilities				
		living do not diminish unless ne individual's clinical condition				
	Į.	iminution was unavoidable.				
		esident's abilities to bathe,				
		transfer and ambulate; toilet; h, language, or other				
		ication systems. A resident				
	who is unable to ca	arry out activities of daily living				
		ervices necessary to maintain		0.		
	good nutrition, grot	oming, and personal hygiene.				
	These REQUIREM evidenced by:	ENTs are not met by				
		ion, interview, and record				
		ailed to ensure a resident who aff received assistance with				
	toileting/incontinen	ce care to 1 of 7 residents (R4)				
	reviewed for activiti	ies of daily living (ADL's) in the				
	sample of 7.					
	The finding include	•				

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Illinois Department of Public Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
***			A. BOILDING.				
		IL6011803	B. WING	<u></u>	06/	12/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
PEARL	OF CRYSTAL LAKE, T	HE	T BRIGHTOI				
()(4) 15	SUMMADV STA	ATEMENT OF DEFICIENCIES	LAKE, IL 6	PROVIDER'S PLAN OF CORR	ECTION	445	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
S9999	Continued From pa	age 2	S9999		-		
	strong smell of urin 9:30 AM, V6 (Certif said she came in a provided incontiner	AM, R4 was lying in bed. A see was permeating from R4. At fied Nursing Assistant-CNA) t 6:00 AM and has not note care to R4. At 9:40 AM, R4 atinence care, R4 was totally e.					
	said incontinence of	PM, V9 (Registered Nurse) care should be provided every eded for resident's comfort.					
	R4's facility assessment dated 4/17/23 shows R4 needs extensive assist of staff for toileting and R4 is always incontinent of bladder functions.						
	Incontinence care a policy with a revise facility will ensure a services and treatn	ry Incontinence and Assessment and Management d date of 6/20/22 states "Our and provide appropriate nents to help residents restore function and prevent urinary e extent possible.					
	(B)						
	2 of 3						
	300.610a) 300.1210d)6)						
	Section 300.610 R	Resident Care Policies					
	procedures govern facility. The writter be formulated by a Committee consist	have written policies and ing all services provided by the policies and procedures shall Resident Care Policy ing of at least the advisory physician or the					

Illinois Department of Public Health

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(X3) DATE SURVEY

Illinois Department of Public Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION IDENTIFICA		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		IL6011803	B. WING		06/1	2/2023
	PROVIDER OR SUPPLIER OF CRYSTAL LAKE, T	1000 EAS	DRESS, CITY, ST T BRIGHTON LAKE, IL 60			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
S9999	medical advisory co of nursing and othe policies shall compl. The written policies the facility and shall by this committee, cand dated minutes. Section 300.1210 (Nursing and Person d) Pursuant to subscare shall include, a and shall be practiced seven-day-a-week. 6) All necessary prassure that the resi as free of accident nursing personnel sthat each resident rand assistance to pursuant to subscare shall include, a and shall be practiced seven-day-a-week. 6) All necessary prassure that the resi as free of accident nursing personnel sthat each resident rand assistance to pursuant seven the facility factories the facility factories with facility factories the facility factories and, in a manner, to aspiration for 1 of 1 enteral feedings in the findings include R4's current care prognitively impaired dementia and cerel showed R4 consumers.	ommittee, and representatives or services in the facility. The lay with the Act and this Part. It is shall be followed in operating I be reviewed at least annually documented by written, signed of the meeting. General Requirements for mal Care Section (a), general nursing eat a minimum, the following ead on a 24-hour, basis: The cautions shall be taken to dents' environment remains hazards as possible. All shall evaluate residents to see receives adequate supervision prevent accidents. ENTs are not met as Sion, interview and recording was administered safely of decrease a resident's risk of residents (R4) reviewed for the sample of 7.				

(X2) MULTIPLE CONSTRUCTION

Illinois Department of Public Health

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IIIInois D	epartment of Public	neaith				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		IL6011803	B. WING		06/1	2/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PEARL C	OF CRYSTAL LAKE, T	HF	T BRIGHTO LAKE, IL 6			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	to his diagnoses of showed, "The resident needelevated 45 degree after tube feed" On June 12, 2023, bed, on his back. Floose cough. The 130 degrees however the bottom of his befootboard. R4's he longer elevated, duenteral feeding was per hour via a pumbed. On June 12, 2023, Nursing Assistant (R4's room to provide the head of R4's bedegrees (no elevation provided incontiner him on and off his state on his bed, as hinfuse at 80 mls per towards the bottom against the footboat the bed with no election upper body as his einfuse. On June 12, 2023, on June 12, 2023, on his back in bed infusing at 80 mls per towards the bottom against the footboat the bed with no election upper body as his einfuse.	dysphagia. The care plan ent will be free of aspiration ds the HOB (head of the bed) is during and thirty minutes at 8:42 AM, R4 was lying in R4 had a frequent, productive, nead of R4's bed was elevated or, R4 was positioned towards ed, with his feet touching the ad was flat on the bed, no e to his positioning. R4's infusing at 80 mls (milliliters) p located to the left of R4's at 9:40 AM, V4 Certified CNA) and V6 CNA entered ded cares. V6 CNA lowered and from 30 degrees to 0 ion). V4 and V6 CNA's then note care to R4, repositioning side, while R4's head remained his enteral feeding continued to	S9999	DEFICIENCY)		
	aspirating. He no le	onger eats at all and is d. He should be sitting more				

Illinois Department of Public Health

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PRO

* · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		IL6011803	B. WING		06/1	2/2023
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PEARLO	OF CRYSTAL LAKE, T	HF	T BRIGHTOI			
CRYSTA			LAKE, IL 6	0012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ae 5	S9999			
	upright when his feethis bed should be edgrees. His tube to when we are doing because rolling him cause him to vomit. The facility's Entera 16, 2022, showed, gastrostomy tube streatment and service pneumonia, diarrhemetabolic abnormatossible, normal eather the streatment and service pneumonia, diarrhemetabolic abnormatossible, normal eather the streatment and service pneumonia, diarrhemetabolic abnormatossible, normal eather the streatment and service pneumonia, diarrhemetabolic abnormatossible, normal eather the streatment and service pneumonia, diarrhemetabolic abnormator and service pneumonia, diarrhemetabolic and service pneumonia, diarrhemetabolic and ser	eding is infusing. The head of elevated around 30-45 feeding should be stopped incontinence care on him back and forth in bed could and possibly aspirate." al Feeding Policy dated June "A resident who is fed by hall receive the appropriate ices to prevent aspiration ea, vomiting, dehydration, elities and to restore, if ating skillsProper elevation ead will be maintained				
	ν-,					
	3 of 3					
	a) The facility shall procedures govern facility. The written	have written policies and ing all services provided by the policies and procedures shall Resident Care Policy				
	Committee consisti administrator, the a medical advisory or of nursing and othe policies shall comp The written policies the facility and shall					

Illinois Department of Public Health

HDQU11

(X3) DATE SURVEY

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

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		IL6011803	B. WING		06/1	2/2023
	PROVIDER OR SUPPLIER OF CRYSTAL LAKE, T	1000 EAS	DRESS, CITY, S T BRIGHTON LAKE, IL 60			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPOSED FICIENCY)	D BE	(X5) COMPLETE DATE
\$9999	f) Infectious Diseas Outbreak Response 4) Upon confirmation member, volunteer, tests positive with a displays symptoms disease, each facilit to prevent the transpractices that include cohorting, isolation environmental clear hygiene, and use of protective equipme. These REQUIREM evidenced by: Based on observation review the facility farequired personal pwhen entering an isolation to 2 residents (R3 in the sample of 7. The findings include On 6/12/23 at 9:10 the door of R3's roow was on isolation an precautions. On 6/12/23 at 9:27 Assistant- CNA) en	of the meeting. dection Prevention and Control ase Surveillance Testing and ase. In that a resident, staff a student, or student intern an infectious disease, or consistent with an infectious by shall take immediate steps mission by implementing de but are not limited to and quarantine, ning and disinfecting, hand f appropriate personal ant. ENTs are not met as on, interview, and record alled to ensure staff used the protective equipment (PPE) colation room for COVID-19 for all reviewed for infection control ase: AM, there were two signs on am. The signs indicated R3 d required contact and droplet AM, V3 (Certified Nursing tered R3's room without ask or eye protection. V3 stated	S9999			

(X2) MULTIPLE CONSTRUCTION

Illinois Department of Public Health

Illinois D	epartment of Public	Health		(20)		
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		IL6011803	B. WING		06/12/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PEARL C	OF CRYSTAL LAKE, T	THE	T BRIGHTON LAKE, IL 60			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
\$9999	Continued From pa	ige 7	S9999			"
	room without wearing protection.	7 AM, V4 (CNA) entered R3's ing a N95 mask or eye 5 PM, V10 (Infection Control			Ballet of the Park	
	Nurse) said R3 had where R3 tested po currently on isolation	d returned from the hospital positive for COVID-19 and was on for COVID-19.				
	required PPE that s a COVID-19 isolation	5 AM, V1 ction Control Nurse) said the staff should use when entering on room, such as R3's room, ask and eye protection.				
	Prevention and Cor COVID-19 Pandem	mmended Routine Infection ntrol Practices During the nic policy dated 5/8/23 showed re protection were to be worn encounters.				
	(B)					

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