(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
				<del></del>					
IL6002976			B. WING 06/06/202			6/2024			
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  471 TERRA COTTA AVENUE								
FAIR OAKS HEALTH CARE CENTER  CRYSTAL LAKE, IL 60014									
(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)	D BE	(X5) COMPLETE DATE			
S 000	Initial Comments		S 000						
	Annual Licensure a	nd Certification							
S9999	Final Observations		S9999						
	Statement of Licensure Violations 1 of 2: 300.650d)								
	Section 300.650 Pe	ersonnel Policies							
		all check the status of all Health Care Worker Registry							
	This REQUIREMENT was not met as evidenced by:								
	failed to ensure Heachecks were compl	and record review the facility alth Care Worker Registry leted prior to hire. This failure affect all residents residing in							
	The findings include	e:							
	The CMS-671 date resided in the facilit	d 6/4/24 showed 34 residents by.							
	were requested for	AM staff background checks the previous 5 hired Certified (CNA's) and the last hired							
	provided Health Ca V16 showed no dat	e was 5/29/24. The facility are Worker Registry check for the when it was completed. (No registry check was completed							

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 07/01/24

TITLE

STATE FORM 6899 If continuation sheet 1 of 4 DWHO11

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6002976	B. WING		06/0	06/2024	
	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  471 TERRA COTTA AVENUE  CRYSTAL LAKE, IL 60014						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
\$9999	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  V17's CNA hire date was 5/30/24. The facility provided Health Care Worker Registry check for V17 showed no date when it was completed. (No documentation the registry check was completed prior to hire.)  V18's CNA hire date was 5/30/24. The facility provided Health Care Worker Registry check for V18 showed no date when it was completed prior to hire.)  V19's CNA hire date was 5/1/24. The facility provided Health Care Worker Registry check for V19 showed no date when it was completed. (No documentation the registry check was completed prior to hire.)  V20's CNA hire date was 5/28/24. The facility provided Health Care Worker Registry check for V20 showed no date when it was completed prior to hire.)  V21's Dietary Aide hire date was 6/3/24. The facility provided Health Care Worker Registry check for V20 showed no date when it was completed prior to hire.)  V21's Dietary Aide hire date was 6/3/24. The facility provided Health Care Worker Registry check for V21 showed no date when it was completed. (No documentation the registry check was completed. (No documentation the registry check for V21 showed no date when it was completed. (No documentation the registry check was completed prior to hire.)  On 6/06/24 at 8:46 AM, V5 Human Resources Manager stated she was responsible for healthcare worker background checks. V5 stated the facility was cited two years ago for not having documented dates when potential new hire health care worker background checks were completed. V5 stated the issue was fixed two years ago and						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			R/SUPPLIER/CLIA ATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
IL6002976		B. WING		06/06/2024					
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
FAIR OA	KS HEALTH CARE C	ENTER		LAKE, IL 6					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETE DATE				
S9999	·		S9999						
	On 6/4/24 at 10:00 were requested for Nursing Assistants dietary aide.  The facility was not	AM staff back the previous (CNA's) and t	5 hired Certified the last hired						
	of Corrections sex								

Illinois Department of Public Health

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AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					COMPLETED			
		IL6002976	B. WING		06/0	6/2024		
	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  471 TERRA COTTA AVENUE  CRYSTAL LAKE, IL 60014							
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE		
\$9999	V16, V17, V18, V19 Aide.  On 6/06/24 at 8:46. Manager stated she healthcare worker be the purpose of back the facility does not	AM, V5 Human Resources was responsible for background checks. V5 stated aground checks was to ensure hire staff who have histories could put the residents at risk.	S9999					

6899

Illinois Department of Public Health STATE FORM

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