STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145612	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Crystal Lake, The	1000 East Brighton Lane Crystal Lake, IL 60012

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to unload the clean dishes from the dishwasher in a sanitary manner and failed to document cooling temperatures. This applies to all the residents in the facility.The findings include:The CMS (Center for Medicare and Medicaid Services) 671 dated 6/2/26 shows there were 77 residents in the facility.On 6/2/26 at 9:24 AM, V4 [NAME] was observed wearing gloves and loading the dishwasher with the dirty dishes. V4 then rinsed her gloves off using the sink sprayer, then wiped them against her cloth apron and began removing the clean dishes from the dishwasher. (V4 did not remove her gloves or wash her hands prior to touching the clean dishes) V4 was observed again doing this at 9:28 AM.On 6/2/26 at 9:59 AM, a pan of cooked cut up chicken was observed in refrigerator with a prepared date of 6/1/26 label. V3 Dietary Manager said he cooked the chicken yesterday and cooled it by resting it in a pan of ice. V3 said he checked the temperatures as it was cooling. V3 said the facility does not use cooling logs or cooling stickers as most foods are cooked the day they are served.On 6/2/26 at 11:10 AM, V3 handed this surveyor a cooling log dated June 2026 showing the chicken was cooked and cooled on 6/1/26.On 6/2/26 at 2:00 PM, V3 said he was the staff that prepared the chicken on 6/1/26 and was doing this because he had some time and wanted to do some meal prep for the next day. V3 said he checked the temperature of the chicken as it was cooling, and he remembered them so he made a cooling log for the surveyor. V3 said the staff are to wash their hands or change their gloves when going between the dirty and the clean dishes.On 6/4/26 at 9:11 AM, V3 was asked for the cooling logs for the last 3 months and provided this surveyor with production logs which did not include any cooling temperatures. V3 said we usually cook food during the day of service.The undated facility policy for hand washing shows food services employees will practice safe food handling to prevent foodborne illness. Workers will thoroughly wash their hands with soap and water after touching anything unsanitary (garbage, dirty dishes).A policy for food cooling was requested, and the facility provided a cooling food log dated June 2026 that shows cool foods from 123 degrees F (Fahrenheit) to 70 degrees F within two hours or less and from 70 Degrees F to 41 degrees F in four hours or less.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer medications as ordered by a physician for 3 residents (R65, R100, R101), failed to safely administer medications to 1 resident (R38), failed to ensure medications were not left at the bedside for 2 residents (R41, R45). These failures apply to 6 of 6 residents reviewed for pharmacy services in the sample of 44. The findings include:1. R38's electronic face sheet dated 6/4/26 showed R38 has diagnoses including but not limited to end stage renal disease, type 2 diabetes, chronic obstructive pulmonary disease (COPD), and depression. R38's facility assessment dated [DATE] showed R38 has no cognitive impairment. R38's June 2026 physician's orders showed R38 receives duloxetine 30mg (milligrams), loratadine 10mg, and sevelamer 800mg at 8:00AM and Lyrica 50mg at 9:00AM. On 6/3/26 at 11:08AM, R38 was sitting up in her room preparing to go on an outing. R38 had a cup of pills in her room sitting on her nightstand. R38 stated, I was nauseous so I had the nurse leave the pills in my room so I can take them later. They are my morning medications. I told the nurse I would take them so it's fine. On 6/3/26 at 11:18AM, V6 (Registered Nurse-Agency) stated, (R38) said she would take her meds, I don't know if she is alert & oriented, but she seems fine to take them I don't have time for her to take them 1 by 1. I have given most all of morning meds, none left to give really. R38's electronic medical record showed no assessment or care plan present for R38 to self-administer her medications. On 6/4/26 at 11:29AM, V2 (Director of Nursing) stated, (R38) has no assessment for self-administration of medications so she should be supervised while taking her medications to ensure she takes them all. 2. R65's electronic face sheet dated 6/4/26 showed R65 has diagnoses including but not limited to dementia with behaviors, Alzheimer's disease, adjustment disorder, and vascular dementia. R65's facility assessment dated [DATE] showed R65 has severe cognitive impairment. R65's June 2026 physician's orders showed R65 receives Depo-Provera 225mg, aspirin 81mg and phosphatidylserine 1200mg at 8:00AM and tizanidine 4mg, guaifenesin 600mg, Colace 100mg, and ferrous sulfate 325mg at 9:00AM. On 6/3/26 at 1:47PM, V2 (Director of Nursing) stated, We are currently checking blood sugars & vitals on all residents who did not get their vitals done or who are late on meds, and we are informing their physician's. We know it's all late but all we can do is catch up now. I didn't realize our agency nurse was getting that far behind today. I still have a few residents to give medications to from this morning. (R65) and (R100) have not received their medications yet. R65's medication administration audit report dated 6/3/26 showed R65 received Depo-Provera 225mg (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	injection and 2:53PM, aspirin 81mg and phosphatidylserine 1200mg at 2:49PM (over 6 hours past the ordered administration time). The facility's policy titled, Medication Administration dated 4/15/26 showed, 19. Scheduled medications will be given within an hour window before and after its scheduled and as preferred by resident. 3. R100's electronic face sheet dated 6/4/26 showed R100 has diagnoses including but not limited to chronic leukemia, acute kidney failure, pneumonia, chronic obstructive pulmonary disease, and emphysema. R100's June 2026 physician's orders showed R100 receives allopurinol 100mg, aspirin 81mg, escitalopram 10mg, folic acid 400mcg, Lasix 20mg, metoprolol 25mg, omeprazole 20mg, potassium chloride 10meq (milliequivalents), simvastatin 10mg, thiamine 100mg, diphenoxylate-atropine 2.5-0.025mg, and gabapentin 100mg at 8:00AM. R100's medication administration dated audit report dated 6/3/26 showed R100 received allopurinol 100mg, escitalopram 10mg, Lasix 20mg, metoprolol 25mg, and potassium chloride 10meq at 2:14PM, aspirin 81mg and omeprazole 20mg at 2:15PM, folic acid 500mcg at 2:16PM, Lasix 20mg and simvastatin 10mg at 2:27PM, thiamine 100mg at 2:11PM, diphenoxylate-atropine 2.5-0.025mg at 2:17PM, and gabapentin 100mg at 1:39PM. (over 5 hours past the ordered administration time). 4. On 6/2/26 at 10:09 AM, R45 was sitting in a wheelchair in her room. R45 had a bottle of Preservision (130 soft gels) on her tray table next to her Trelegy Ellipta inhaler. V9 Licensed Practical Nurse came into the room and was shown the medication at bedside. R45 stated she wasn't sure if the inhaler was left at the bedside because the resident has contact precautions in place. V9 left the room, went to her medication cart to review the resident's record with the surveyor. V9 confirmed there wasn't an order to leave the medications at the bedside or for self-administration of medication. V9 reviewed R45's care plan with the surveyor present and stated there wasn't a plan in place for self-administration of medications. The Physician Orders dated June 2026 for R45 showed an order was entered on 6/2/26 after the observation at 10:09 AM, for the Preservision Areds 2, 1 capsule by mouth two times a day – supervised self-administration. R45 had an existing order in place for Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 MCG (micrograms)/ACT (actuation)(Fluticasone-Umeclidinium-Vilanterol) - 1 puff inhale orally one time a day for COPD, rinse mouth after use, date and discard after 42 days. The order did not include self-administration or keeping it at bedside. The Care Plan dated 5/14/26 for R45 did not have a plan in place for self-administration of medication. On 6/3/26 at 2:58 PM, V1 Administrator/Registered Nurse stated for residents to self-administer medications there is a policy/process. The residents need to be educated on what the medications are for, when they are taken, etc. There needs to be a doctor's order and assessment for self-administration of medications before it can be done. The resident needs to have a care plan in place for self-administration of medication. The facility's Self Administration of Medication Program policy (4/25/25) showed it is the policy of (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility to allow the resident and or legal representative of the resident the right to self-administer medication when it's been deemed by the interdisciplinary team that it is clinically appropriate. The facility will allow the resident to self-administer drugs if the interdisciplinary team (IDT team), has determined this practice is safe. Nurse will complete a Self- Administration of Medication Assessment. The IDT team must also determine who will be responsible for storage (if medications are stored at the resident's bedside, a lockbox or locked drawer must be used to store medications). 5. On 6/3/26 at 10:27 AM, R41 was sitting in a wheelchair in his room. R41 had oxygen at 4 liters/min (minute) per nasal cannula. There was an albuterol inhaler lying on the tray table in his room. On 6/3/26 at 2:58 PM, V1 Administrator/Registered Nurse stated for resident to self-administer medications there is a policy/process. The residents need to be educated on what the medications are for, when they are taken, etc. There needs to be a doctor's order and assessment for self-administration of medications before it can be done. The resident needs to have a care plan in place for self-administration of medication. The Face Sheet dated 6/4/26 for R41 showed diagnoses including pneumonia, pulmonary embolism, acute on chronic systolic congestive heart failure, pleural effusion, paroxysmal atrial fibrillation, Guillain-Barre syndrome, type 2 diabetes mellitus, dyspnea, anxiety disorder, dependence on supplemental oxygen, burn of unspecified degree of abdominal wall, sacral pressure ulcer, deep vein thrombosis, major depressive disorder, hypotension, hyperlipidemia, atrial fibrillation, hypokalemia, depression, polyneuropathy, restless leg syndrome, and cardiomegaly. The Physician Orders dated June 2026 for R41 showed Ipratropium-Albuterol inhalation solution 0.5-2.5 (3) MG/ML (milliliter), 1 dose inhale every morning and at bedtime for shortness of breath/wheezing. There were no orders for self-administration or storage at the bedside. The Care Plan dated 6/2/26 for R41 showed he has the potential for shortness of breath related to acute pulmonary embolism, congestive heart failure, pneumonia, and pleural effusion. The care plan did not show anything regarding self-administration of medication or storage of medication at bedside. 6. R101's admission Record (Face Sheet) showed an admission date of 6/1/26 with diagnoses to include but not limited to joint replacement surgery, high blood pressure, anxiety, and depression. R101's 6/1/26 Health Status note from 4:53 PM showed she arrived at the facility. The note showed she was oriented to person, place, time, and her current condition. On 6/2/26 at 11:35 AM, R101 stated the facility was given a list of her medications and the facility failed to enter them in time for her to receive her evening blood pressure medication. R101 said, I didn't get my blood pressure medication last night and this morning my blood pressure was 183 or something like that. Normally I'm 120. They really didn't care. The blood pressure thing scared me. R101's blood pressure documentation from 6/2/26 at 6:36 AM showed it was 175/80 (The upper limit of normal is 120/80). R101's blood pressure documentation showed her blood pressure at 10:08 AM was 145/78 (after her morning blood pressure medication was administered.) R101's June 2026 Medication Administration Record (MAR) showed and order for carvedilol (blood pressure medication) 25 milligrams to be given twice daily. The MAR showed the 5:00 PM dose on 6/1/26 was not given. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/4/26 at 10:31 AM, V2 Director of Nursing stated medications are not ordered for a resident until they arrive to the facility. V2 said if an ordered medication is not available for a resident the staff should check the facility's supply and if it is not available the medication should be ordered stat from the pharmacy. The facility's Medication Administration policy (reviewed 4/15/26) showed, All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. If medication is ordered but not present check to see if it was misplaced and then call the pharmacy to obtain the medication. If available, obtain the emergency or convenience box.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review the facility failed to notify a resident's provider when the resident's blood sugar was outside the specified parameters. This applies to 1 of 1 residents (R7) reviewed for notification in the sample of 44.The findings include:R7's admission Record (Face Sheet) showed she was a type two diabetic.R7's Order Listing Report showed an order with a last order date of 3/20/26 which showed .notify MD (medical doctor) if 2 consecutive blood sugars are greater than 349.R7's Blood Glucose documentation showed on 3/23/26 at 6:01 AM a blood sugar of 401, then at 8:24 AM a blood sugar of 390, and finally at 11:49 a blood sugar of 368.R7's Electronic Health Record (EHR) showed no documented communication between nursing staff and R7's provider.On 6/04/2026 at 10:47 AM, V2 Director of Nursing stated, staff should be following orders as written and notifying providers when ordered to do so. V2 states she was not able to find any documentation that R7's provider was notified of the three consecutive blood sugars being greater than 349. V2 stated the purpose of notifying the provider of these elevated values was to keep the provider informed and to possibly adjust R7's insulin dose.The facility's Notification of Change in Condition policy (reviewed 1/15/26) showed, It is the policy of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate. The policy showed, after documentation the nurse will .Document the notification and record any new orders in the resident 's medical record.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on observation, interview, and record review the facility failed to ensure the transfer to the hospital was documented and the basis for transfer was documented for 1 of 1 resident (R77) reviewed for transfers in the sample of 44.The findings include:On 6/4/26 at 9:10 AM, R77 wasn't in her room and her belongings including wheelchair were in the room. V14 Registered Nurse was in the hallway and stated R77 went to the hospital after becoming unresponsive at dialysis the day before (6/3/26).The Progress Notes for R77 were reviewed for 6/3/26 and showed at 1:58 AM she had an episode of emesis. At 4:06 PM a skilled charting note was entered that showed vitals signs, mental status as alert and oriented x 3 (person, place, and time), and functional status. There was no note in R77's chart to show what happened, why the resident was sent out of the facility, or where she went.On 6/4/26 at 9:49 AM, V2 Director of Nursing stated R77 was at dialysis, and she wasn't responding like normal. R77 was not at her baseline; she had a change in condition. R77 was sent to the hospital. V2 stated normally an e-interact SBAR (situation, background, assessment, recommendation) is documented in the resident's record. The documentation for the resident was reviewed with V2 who confirmed that there was no note showing what happened to R77, where she went, why she was sent out, of follow up information.The Notification of Change in Condition, Discharge and Transfer policy (1/15/26) showed if a resident becomes unstable or deteriorates, the situation becomes urgent, and emergency procedures apply (emergency services may be called without waiting for orders). Document everything. All attempts to contact providers, the residents' status, and nursing actions must be documented.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review the facility failed to provide nail care for a 1 of 1 residents (R9) reviewed for activities of daily living in sample of 44. The findings include:R9's admission Record (Face Sheet) showed an admission date of 11/5/24 with diagnoses to include but not limited to paralysis affecting his right side, dementia, and cognitive communication deficit.R9's 5/8/26 Significant Change Minimum Data Set (MDS) showed he had severe cognitive impairment with a Brief Interview for Mental Status score of 5 out 15. The MDS showed he required substantial/maximal assistance (helper does more than half the work) for both personal hygiene and showering/bathing. The MDS showed he had an impairment to one side of his upper body.On 6/2/26 at 11:13 AM, R9 was asleep on his back in bed. R9's right hand appeared stiff and contracted. R9's fingernails on both hands were dirty and approximately 0.25 inches past the cuticle bed.On 6/3/26 at 1:41 PM, R9 was up in his wheelchair. R9's fingernails were in the same condition as they were on 6/2/26. R9 said, My nails are long, they need to be trimmed. Would you be able to do that. R9 was asked if he would like this surveyor to find a staff member to trim his nails. R9 replied, Would you do that? I would appreciate it. R9 said he liked having his nails trimmed and I don't like them being long.On 6/3/26 at 2:01 PM, V8 Certified Nursing Assistant (CNA) stated, He (R9) needs assistance with pretty much all of his care. He can't move his right hand, but he does feed himself with his left hand. He works well with us; he doesn't refuse care. On shower day we do nails and shave. CNAs can do fingernails. Trimming nails is important for bacteria, it can prevent an infection. R9's fingernails were then observed with V8. V8 stated, It doesn't look like they have been trimmed in a while. They do need to be trimmed. V8 stated it was the end of her shift, and she would pass on R9's nail care to the next shift. On 6/4/26 at 9:24 AM, R9's nails showed they had been trimmed.On 6/4/26 at 10:56 AM, V2 Director of Nursing stated that nail care should be offered on shower days. V2 said nail care is important for hygiene and cross-contamination.The facility's Supporting Activities of Daily Living policy (reviewed 12/4/25) showed Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs): Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure pressure ulcer prevention measures were in place for 2 of 7 residents (R62,R65) reviewed for pressure ulcers in the sample of 44. The findings include:1. R62's electronic face sheet dated 6/4/26 showed R62 has diagnoses including but not limited to displaced fracture of right femur, age-related osteoporosis, hypertension, pressure-induced deep tissue damage of right heel, pressure ulcer of sacral region-unstageable. R62's facility assessment dated [DATE] showed R62 has no cognitive impairment, is at risk for developing pressure ulcers, has one stage 1 pressure ulcer, and two unstageable pressure ulcers. R62's care plan dated 5/22/26 showed, (R62) has PUs (pressure ulcers) to her sacrum and right heel related to impaired mobility, fall with femur fracture and surgery, recent MASD (moisture associated skin damage) with incontinence, not repositioning much on her own in the bed .offload heels. R62's wound assessment dated [DATE] showed, right heel 5.40 x 4.00 x 0.10 (L x W x D) (present upon admission) deep tissue injury .Seen by wound nurse practitioner for the first time. The blister had opened prior to seeing today. On LAL (low air loss) mattress and reminded to use the heel protector boots while in bed. Skin prepped and bordered foam applied. No pain to site. Continuing with care. On 6/2/26 at 10:27AM, R62 stated, I'm not sure what all they are doing about my sores. They put the boots on my feet, I was getting sores on the back of my foot and those keep it from happening, I don't need them all the time, I shouldn't be in bed all the time. R62's pressure relieving heel boots were sitting in the chair next to her bed. On 6/4/26 at 11:10AM, R62 was laying in her bed with her heels flat on the bed. R62's pressure relieving heel boots were sitting in the chair next to her bed. On 6/4/26 at 11:16AM, V10 (Certified Nursing Assistant-CNA) stated, (R62) has a few pressure ulcer prevention measures in place. She uses an air mattress, heel boots, and side to side turning. She is compliant with everything. I'm not sure why she wouldn't have her heel boots on if she is in bed. She has no problem letting us put them on.On 6/4/26 at 11:29AM, V2 (Director of Nursing) stated, Pressure ulcer prevention measures are put in place to prevent a pressure ulcer. (R62's) interventions are a low air loss mattress and heel protectors while in bed. It seems like a contraindication for the prevention measures with the air mattress but if that is what is on their care plan then that is what we should be doing.2. R65's electronic face sheet dated 6/4/26 showed R65 has diagnoses including but not limited to frontotemporal neurocognitive disorder, dementia with behaviors, vascular dementia, peripheral vascular disease, anxiety disorder, and adjustment disorder. R65's facility assessment dated [DATE] showed R65 has severe cognitive impairment and is at risk for pressure ulcers. R65's care plan dated 2/10/26 showed, (R65) recently had discolorations to bilateral popliteal areas related to restless legs while up in chair and bumping wheelchair or (reclining wheelchair) arm rest, strap and bar .pillow or sheet between legs and wall to keep from bumping. R65's care plan dated 1/13/26 showed, (R65) has potential for impairment to skin integrity related to fragile skin, incontinence, glasses too tight or too loose sometimes causing irritation to nose, restless legs while in wheelchair and in bed- causing leg discolorations, history of falls, impaired mobility, MASD and scratches at skin- mostly buttock/groin .offload heels with pillows when in bed. On 6/2/26 at 10:18AM, R65 was laying down in his bed with the head of bed elevated approximately 30 degrees. R65 had no pillow between his legs and his knees were rubbing together. R65 was rubbing his feet/heels back and forth on his bed with no pressure relief device in place. A wedge cushion and knee separation cushion were located on R65's bedside table across the room. On 6/2/26 at 1:22PM, V17 (CNA) provided incontinence care to R65 and laid him down for the afternoon. V17 completed her care for R65 and put a blanket over him without elevating his heels off the bed. V17 stated R65 does not wear heel boots and will pull his feet up off the mattress every so often. On 6/4/26 at 11:09AM, R65 was lying in his bed with no pressure prevention device on his feet or between his knees. On 6/4/26 at 11:16AM, V10 (Certified Nursing Assistant-CNA) stated, (R65's) pressure ulcer prevention measures are an air mattress, laying down, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	repositioning, and pillows to elevate his heels. We put pillow in between his legs as well, so his knees don't rub together and create a sore. I'm not sure why his prevention measures are not in place right now because everything is in his room. On 6/4/26 at 11:29AM, V2 stated, (R65's) pressure ulcer prevention measures are a low air loss mattress and lamb's wool. I don't see anything else unless it's on his care plan but if has alternative measures on his care plan then that's what he should be getting. The facility's policy titled, Pressure Injury Evaluation, Assessment, Risk Reduction, and Long-Term Healing dated 4/2026 showed, 1. The facility will ensure that based on the comprehensive assessment of a resident: a. A resident receives care, consistent with professional standards of practice, to prevent pressure injuries. b. A resident with a pressure injury receives necessary treatment and services, consistent with professional standards of practice, that are aimed to promote healing, minimize complications and prevent the development of further pressure injury .3. Interventions will be implemented in the resident's plan of care to prevent pressure injury development when the resident has no areas of concern .5. Interventions will be implemented in the resident's plan of care to prevent deterioration and promote healing of the pressure injury .

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	145612	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Crystal Lake, The	1000 East Brighton Lane Crystal Lake, IL 60012

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure fall preventative measures were in place for a resident at high risk for falls for 1 of 4 residents (R45) reviewed for falls in the sample of 44.The findings include: On 6/2/26 at 10:09 AM, R45 was sitting in a wheelchair in her room. R45 had oxygen on via a nasal cannula. R45 had a small portable oxygen tank sitting on her dresser across the room. The oxygen tubing was coming from the portable tank on the dresser, draped across the bed and coiled on the floor in front of the resident. R45 stated she has been in and out of the facility for rehabilitation services and has had 17 falls in 6 months. R45 stated she is not supposed to get up on her own but has done so when waiting for help going to the bathroom. R45 stated she fell at the facility when trying to overstep the oxygen tubing and it got caught around her ankles.On 6/3/26 at 3:05 PM, V2 Director of Nursing stated R45 was at high risk for falling and the oxygen tubing should be out of the way and not laying on the floor; R45 could fall.The Face Sheet dated 6/4/26 for R45 showed diagnoses including fall on same level, chronic obstructive pulmonary disease, Type 2 diabetes mellitus, morbid obesity, long term use of anticoagulants, abnormality of gait and mobility, lack of coordination, anxiety disorder, rheumatoid arthritis, presence of left artificial knee joint, and dependence on supplemental oxygen.R45's Minimum Data Set, dated [DATE] showed no cognitive impairment.The SBAR note dated 5/13/26 at 7:49 PM for R45 showed the nurse was called to the resident's room and R45 was sitting on the floor at the toilet. R45 stated she was trying to untangle the oxygen tubing around her feet and landed on the floor.The Care Plan dated 5/9/26 for R45 showed she is at high risk for falls related to frequent falls at home, weakness/deconditioning due to bacteremia, urinary tract infection, and cholecystitis. R45's care plan showed she had an actual fall on 5/14/26.The facility's Fall Prevention and Management Policy (3/25/26) showed high risk residents and patients for falls will receive individualized interventions as appropriate to risk factors. Fall focus program will be implemented to all residents admitted to the facility regardless of risk scores. Fall Risk Program will be implemented to ensure purposeful rounding addresses residents positioning, pain, personal needs, personal items within reach, perils/safety hazards, and peaceful environment upon admission and throughout resident's stay.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review the facility failed to ensure a resident's nebulizer was stored in a manner to prevent cross contamination for 1 of 1 residents (R41) reviewed for oxygen/respiratory treatments in the sample of 44.The findings include: On 6/3/26 10:27 AM R41 was sitting in a wheelchair in his room with oxygen on via nasal cannula. R41 had a nebulizer machine on his nightstand. The drawer to the nightstand was open and the face mask to his nebulizer machine was uncovered and laying in the drawer with other items. R41 had an albuterol inhaler and incentive spirometer on his tray table. R41 stated he would be okay if his breathing was better. R41 stated he was in the hospital for 26 days because of pneumonia and a blood clot. R41 stated during his hospitalization he spent time in the intensive care unit. R41 stated he was diagnosed with Guillain Barre in December 2025.On 6/3/26 at 2:58 PM, V1 Administrator/Registered Nurse stated the nebulizer mask should be stored in a bag and covered for infection control.The Face Sheet for R41 showed diagnoses including pneumonia, pulmonary embolism, acute on chronic systolic congestive heart failure, pleural effusion, paroxysmal atrial fibrillation, Guillain-Barre syndrome, type 2 diabetes mellitus, dyspnea, anxiety disorder, dependence on supplemental oxygen, burn of unspecified degree of abdominal wall, sacral pressure ulcer, deep vein thrombosis, major depressive disorder, hypotension, hyperlipidemia, atrial fibrillation, hypokalemia, depression, polyneuropathy, restless leg syndrome, and cardiomegaly. The Physician Orders dated June 2026 for R41 showed Ipratropium-Albuterol inhalation solution 0.5-2.5 (3) MG (milligrams)/ML (milliliter), 1 dose inhale every morning and at bedtime for shortness of breath/wheezing. The Care Plan dated 6/2/26 for R41 showed he has the potential for shortness of breath related to acute pulmonary embolism, congestive heart failure, pneumonia, and pleural effusion. The Care Plan dated 6/2/26 for R41 showed he has oxygen therapy related to recent pneumonia, acute pulmonary embolism with acute respiratory failure, and pleural effusion. The Facilities Nebulizer Therapy policy (4/1/23) showed, store in a plastic bag.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review the facility failed to provide pain medication for a resident prior to therapy. This applies to 1 of 1 residents (R101) reviewed for pain control in the sample of 44.The findings include:R101's admission Record (Face Sheet) showed an admission date of 6/1/26 with diagnoses to include but not limited to joint replacement surgery, right artificial knee joint, and type two diabetes. R101's 6/1/26 Health Status note from 4:53 PM showed she arrived at the facility. The note showed she was oriented to person, place, time, and her current condition.On 6/2/26 at 11:35 AM, R101 I asked if I could have my pain pill before therapy and that didn't happen. My therapy was at 10:00 AM. I asked for it earlier in the morning. I know they are busy but they act like they don't care. My therapy hurt this morning, the pain pill would have helped.On 6/2/26 at 1:42 PM, V7 Registered Nurse stated she was R101's nurse. V7 said, She had a right knee replacement. I gave her [hydrocodone/acetaminophen]. (A combination narcotic and over the counter pain medication, which comes in several different narcotic strengths.) I gave her the 10 milligram dose because she said her pain was bad. She didn't ask me for pain meds before therapy. I don't know when therapy is going to be done for the residents. For patients like her with knee replacements, therapy can be painful. Often times therapists will tell us they are going to take a resident and tell us to give them something for pain but they didn't this time. The therapists didn't tell me she was having pain either. Giving the pain medication before therapy can also be helpful to stay ahead of the pain and also it helps them do more with therapy.R101's 6/2/26 Health Status Note from 5:30 PM showed she left the facility AMA (against medical advice).On 6/4/26 at 11:06 AM, V11 Therapy Director stated prior to therapy the therapist will try and speak with the resident and tell them to request pain medication prior to therapy, if needed. V11 said residents with recent joint replacements can have pain with therapy. V11 said the pain medication can allow the resident to endure therapy and allow the resident to do more in therapy.R101's Medication Administration Record showed R101 was given a tablet of hydrocodone/acetaminophen at 11:07 AM on 6/2/26 for pain rating of 8 out of 10. (Given after R101 stated therapy had been done.)The facility's Pain Management policy (reviewed 10/30/25) showed The facility will provide adequate pain assessment and management to that residents attain or maintain the highest practicable physical, mental, and psychosocial well-being.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure a resident (R66) was free from a significant medication error. This applies to 1 of 1 residents reviewed for significant medication errors in the sample of 44. The findings include:R66's electronic face sheet dated 6/4/26 showed R66 has diagnoses including but not limited to congestive heart failure, hypertension, type 2 diabetes, and cirrhosis of the liver. R66's physician's orders dated 5/21/26 showed, Humalog 100 unit/mL (milliliter) Inject as per sliding scale subcutaneously with meals for diabetes mellitus. On 6/3/26 at 1:47PM, V2 (Director of Nursing) stated, It doesn't look like (R66) got her insulin at noon today with her lunch. We are currently checking blood sugars and vitals on all residents who did not get their vitals done or who are late on medications, and we are informing their physician's. We know it's all late but all we can do is catch up now. I didn't realize our agency nurse was getting that far behind today. R66's medication administration report showed R66 received her Humalog Insulin at 1:58PM. (1 hour and 58 minutes past the scheduled administration time). The facility's policy titled, Medication Administration dated 4/15/26 showed, 19. If the medication is given at a time different from the scheduled time, updated the MAR (Medication Administration Record) to reflect administration time. Scheduled medications will be given within an hour window before and after its scheduled and as preferred by resident .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to puree foods following the recipe to maintain palatability of the food served. This applies to two of two residents (R9, R65) reviewed for puree foods in the sample of 44.The findings include:On 6/2/26 at 10:50 AM, V4 [NAME] was preparing the puree foods for lunch. V4 was pureeing the Asian fried rice and was adding plain hot water to the blender to puree the rice to the correct consistency. V4 and this surveyor tasted the mixture when she was done pureeing the rice and the rice had no flavor. V4 was told by V3 Dietary Manager (DM) to add some salt which she did.On 6/2/26 at 11:19 AM, V4 said the rice was cooked in chicken broth and that is why she used the water to help puree the rice to the correct consistency.On 6/2/26 at 2:00 PM, V3 DM said V4 should have used chicken broth as the liquid to puree the rice. V3 said he had started to boil a pot of water to make some broth, and V4 took the water before he could complete that.On 6/3/26 at 11:44 AM, V5 Dietician said if the recipe calls to add broth to the rice while it is being pureed, that is what the staff are to do. V5 said chicken broth would make the rice more palatable for the residents.The recipe for Asian Fried [NAME] shows to process the rice in food processer until smooth pudding like consistency is achieved. Add juice, milk or broth, whichever is most appropriate for the item being pureed, a little at a time to achieve desired consistency.The facility face sheet for R9 shows he was admitted to facility with diagnoses to include dementia and dysphagia (Difficulty swallowing). A Physician order dated 3/23/26 for R9 shows he is to have pureed foods.The facility face sheet for R65 shows he was admitted to the facility with diagnoses to include Alzheimer's Disease. A Physician order dated 3/5/26 shows R65 to be served pureed foods.The undated facility policy for Standardized Recipes shows the recipes are to be followed throughout production.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to ensure enhanced barrier precautions were followed for 1 of 7 residents (R21) reviewed for infection control in the sample of 44.The findings include:On 6/2/26 at 10:28 AM R21 had an enhanced barrier precautions (EPB) sign up on doorway to his room. R21 was in bed on his back with the head of his bed elevated. R21 had an air mattress in place on his bed and stated that his bottom hurt because it felt like the bed was inflated enough. R41 stated it felt like his bottom was touching the metal of the bed. V12 Certified Nursing Assistant came into his room, did not have gloves or gown on and removed his blankets, was touching/pressing all over the mattress to check the inflation. V12 moved the linen around on his bed to look at the mattress. At 10:46 AM V13 Restorative Nurse came into the room, put gloves on, did not have a gown on and on and started pushing on the mattress to check the inflation. V13 also put her hands and forearms under the resident to see if the mattress was flat under him. V12 and V13 were asked why the EBP sign was up and what it meant. V12 stated that R21 had surgery to remove his feeding tube and the site came open last week and was draining so that is why he was on the EBP. V13 stated EBP was for residents with a stage 3 or higher open wound and that is when the EBP has to be followed.On 6/2/26 at 11:07 AM, V12 looked at the EBP sign and stated she should have had gloves on when touching R21 and his linen because it was close contact.On 6/4/26 at 3:05 PM, V2 Director of Nursing stated staff should follow the EBP sign and do what it says. V1 was present and agreed that if the EBP sign is posted then it should be followed. They stated gown and gloves should be worn with the high contact care.The Physician Orders for June 2026 for R21 showed EBP precautions for surgical wound site.The Care Plan dated 6/1/26 for R21 showed he is on enhanced barrier precautions related to his surgical site. To alleviate and reduce further the spread of infection through early recognition and to allow prompt treatment. Clean/wash hands, including before entering and when leaving the room wear gloves and a gown for High Contact Resident Care Activities: dressing, bathing/showering, transferring, changing linens, providing hygiene care, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, wound care: any skin opening requiring a dressing.The facility's Enhanced Barrier Precautions policy (1/14/26) showed enhanced barrier precautions is an approach of targeted gown and glove use during high contact resident care activities to reduce the transmission of staphylococcus aureus and multidrug resistant organisms. When a resident is placed in enhanced barrier precautions, gown and gloves will be used during high-contact resident care activities.