STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6022653	A. BUILDING: _____ B. WING _____	C 05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT CRYSTAL LAKE	495 ALEXANDRA BLVD CRYSTAL LAKE, IL 60014

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A 000	Initial Comment Investigation of Complaint #2676174/IL201931 Violations: 295.4010d)e) 295.4060 a)c)f) 295.6000a)13) Facility Reported Incident 5/12/2026 - IL201848 Violations: 295.4010d)e) 295.4060 a)c)f) 295.6000a)13)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section	A4010		

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A4010	Continued From page 1 295.4000). These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to ensure a resident's service plan was updated and interventions were in place for a resident with aggressive behaviors following an incident with another resident. This failure creates a substantial probability of harm to a resident or residents. This applies to 1 of 3 (R1) residents reviewed for service plans in the sample of 7. Findings include: On 5/18/2026 at 10:19AM, E2 (Wellness Director) said after [R1's] incident with [R2] that [R1] was placed on 1:1 supervision. On 5/18/2026 at 12:05PM, E2 said she has not updated [R1's] service plan since the incident with [R2]. E2 said she normally updates the service plans within 24 hours. On 5/18/2026 at 8:55AM, E2 said [R1] was sent out to the hospital on 5/12/2026 for evaluation. E2 said [R1] returned from the hospital the same day between 8:30PM - 9:00PM. On 5/18/2026 at 11:58AM, E1 (Executive Director) said they had called Z1 [R1's Wife] to come sit with him overnight. E1 said on the morning of 5/13/2026 she found out [Z1] did not come sit with [R1] overnight. The establishment failed to provide a service plan for R1 which was updated prior to the start of the survey on 5/18/2026, noting his 1:1 supervision.	A4010		

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A4010	Continued From page 2 The facility provided Individual Service Plan (ISP) policy dated 4/2026 states, . . . After an assessment and/or reassessment of a resident is conducted upon admission, semi - annually, or when there is a change in condition regarding daily needs, physical abilities, and mental status to determine level of care for Assisted Living, an Individual Service Plan (ISP or care plan) must be completed for each resident. . .	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 1 Violation Section 295.4060 Alzheimer's and Dementia Programs a) In addition to this Section, Alzheimer and dementia programs shall comply with all of the other provisions of the Act. (Section 150(a) of the Act) c) No persons shall be accepted for residency or remain in residence if the person's mental or physical condition has so deteriorated to render residency in such a program to be detrimental to the health, welfare or safety of the person or of other residents of the establishment. The assessment must be approved by the resident's physician and shall occur prior to acceptance for residency, annually, and at such time that a change in the resident's condition is identified by a family member, staff of the establishment, or the resident's physician. (Section 150(c) of the Act)	A4060		

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A4060	Continued From page 3 f) No person shall be accepted for residency or remain in residence if the person meets the criteria provided in subsections (b) through (g) of Section 75 of the Act. (Section 150(e) of the Act) These requirements are not met as evidenced by: Based on interview and record review the establishment failed to terminate residency of an individual who was having increasing behaviors of yelling and aggression towards residents and staff. This applies to 1 of 1 (R1) reviewed for residency requirements. This failure creates a substantial probability of severe harm to a resident or resident. Findings include: On 5/18/2026 at 9:49AM, E4 (Caregiver) said [R1's] behaviors have gotten worse since his admission, including screaming and hollering. E4 said [R1] verbally abusive to staff and residents. On 5/18/2026 at 8:55AM and 10:19AM, E2 said [R1] can be verbally aggressive with staff and residents. E2 said [R1] was an involuntary admission to the behavioral unit and was issued a 30-day notice. E2 said [R1] left on 5/13/2026 at approximately 3:30PM with [ambulance service] and has not returned to the building since. R1's Resident Information sheet dated 5/18/2026 lists an admit date of 4/20/2026. R1's Resident Information sheet dated 5/18/2026 lists diagnoses including but not limited to, moderate to late onset Alzheimer's dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety, and	A4060		

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A4060	Continued From page 4 Chronic moderate late onset Alzheimer's dementia with recent hospitalization for agitation and behavioral symptoms. Improved wandering and violence since discharge, but persistent confusion and need for nursing level care. . . R1's Recent Notes regarding behaviors are as follows: On 4/24/2026 at 1:45PM and 7:45PM notes the resident yelling at staff and/or having delusional behaviors. At 7:45PM the note also states the resident urinated on a couch cushion and isn't easily redirectable. On 4/27/2026 at 1:30PM and 9:15PM notes the resident exit seeking behavior, increased anxiety and/or agitation. On 4/30/2026 at 8:45PM and 9:45PM notes show the resident was sent out of the facility after 911 was called related to [R1] grabbing another resident's wheelchair and touching the other resident. Additionally, it notes confusion with [R1] thinking the other resident was his wife. At 9:45PM notes indicate the resident returned to the establishment following an ER visit. On 5/2/2026 at 1:15PM and 9:30PM notes indicate the resident was yelling and/or agitated requiring as needed medication administration of 0.5 Alprazolam. On 5/3/2026 at 1:15PM notes show again [R1] was medicated with 0.5 Alprazolam for anxiety, noting the resident pulled clothing out of drawers and braced a dresser in front of resident's room while refusing to leave the room. On 5/5/2026 at 5:45PM recent notes state the	A4060		

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A4060	Continued From page 5 resident had exit seeking behaviors overnight. On 5/9/2026 at 6:00PM notes state the resident was confused, delusional, and yelling at staff. On 5/12/2026 at 8:15PM notes show the resident was transferred to a [Local Area Hospital] following an altercation with another resident resulting in the other resident falling and hurting himself.	A4060		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 1 Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to keep residents free from abuse, resulting in one resident sustaining a fracture. This failure creates a substantial probability of severe harm or death to a resident or residents. This applies to 3 of 7 residents	A6000		

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A6000	Continued From page 6 reviewed for abuse in the sample of 7. Findings include: On 5/18/2026 at 9:49AM - E4 (Caregiver) said she was working on 5/12/2026. E4 said she approached [R1] and he was in the hallway near the exit door and seemed agitated and was exit seeking. E4 said she heard a resident yelling for help. E4 said she went into [R2's] room and found him lying on the floor and his right arm was bleeding. E4 said [R2] stated [R1] had come into his room and was yelling about work stuff. E4 said [R2] stated he told [R1] to leave and [R1] was arguing with [R2]. [R2] said he was pushed by [R1] and he fell down near his bathroom. E4 said [R2] reported hitting his head when he fell. E4 said [R1's] behaviors have gotten worse since his admission, including scream and hollering. E4 said [R1] verbally abusive to staff and residents. E4 said [R1] told everyone who came in the room about what happened, and it was always the same story. On 5/18/2026 at 9:10AM - E3 (Licensed Practical Nurse - LPN) said on 5/12/2026 he was working. E3 said he heard a loud sound and a resident using foul language and cussing. E3 said he saw [R1] standing outside of [R2's] room. E3 said he went to assess [R2] in his room and he was on the floor. E3 stated [R2] told him [R1] had come into his room and saw him on the floor. E3 said he asked [R2] how he got on the floor and [R1] told him the guy outside his room [R1] had pushed him and he fell. E3 said [R2] was sent out to the hospital and did not return. E3 said [R2] is alert and oriented. E3 said on another day he saw [R1] grab [R3's] arm before because he thought she was his wife. E3 said 911 was called that day and [E2] was notified.	A6000		

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A6000	Continued From page 7 On 5/18/2026 at 8:55AM and 10:19AM, E2 (Wellness Director) said she entered [R2's] room on 5/12/2026 and [R2] was on the floor with his walker tipped over. E2 said [R2] stated [R1] came in his room yelling when [R2] was coming out of the bathroom. E2 said [R2] stated [R1] threw him on the ground and [R2] was complaining of left hip pain and his head hurt on the right side. E2 said [R1] is delusional at baseline and was confused that day thinking the year was 1961 and he was getting fired. E2 said [R1] can be verbally aggressive with staff and residents. E2 said [R1] is alert and oriented and is not known for making up stories. E2 said on 4/30/2026 the police were called because [R1] had grabbed [R3's] wheelchair and arm and then yelled at [R7]. E2 said she walked by the game room and heard yelling, and she turned and [R1] was yelling at [R7], but couldn't make out what he was saying. E2 said grabbing wheelchairs, people's arms, or yelling is not acceptable behavior because it's a violation of the residents rights and its abuse. On 5/18/2026 at 2:10PM, E7 (Caregiver) said she was working and it was around 3:00PM during snack time. E7 said [R2] was yelling and holding onto [R3's] arm and wheelchair. E7 said [R2] thought [R3] was his wife. E7 said staff tried to separate the residents and [R1] was grabbing onto her wheelchair armrest and pulling on her left upper arm. R2's After Visit Summary states, . . . you were admitted to the hospital because of a fall and a pubic bone fracture. . . R1's Resident Information sheet dated 5/18/2026 lists diagnoses including but not limited to, moderate to late onset Alzheimer's dementia	A6000		

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A6000	Continued From page 8 without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety, and Chronic moderate late onset Alzheimer's dementia with recent hospitalization for agitation and behavioral symptoms. Improved wandering and violence since discharge, but persistent confusion and need for nursing level care. . .	A6000		