Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0051052	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL PINES REHAB & HCC	335 NORTH ILLINOIS AVENUE , CRYSTAL LAKE, Illinois, 60014

(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) COMPLETION DATE
S0000	Initial Comments Facility Reported Incident Investigation of October 7, 2025/2639220	S0000		
S9999	Final Observations Statement of Licensure Violations 300.1210d)6) 300.2210b)5) 300.2410a) Section 300.1210 General Requirements for Nursing and Personal Care 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. Section 300.2210 Maintenance b) Each facility shall: 5) Maintain all furniture and furnishings in a clean, attractive, and safely repaired condition. Section 300.2410 Furnishings a) Each resident shall be provided with a separate bed suitable to meet the needs of the resident. Each bed shall be at least 36 inches wide, have a headboard, be of sturdy construction and be in good repair. A double bed shall be provided for married couples if they request this arrangement and if there are no medical contraindications. These requirements were not met as evidenced by:	S9999		

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

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S9999	Continued from page 1 Findings include: R1's Face Sheet dated October 14, 2025, shows R1 was admitted to the facility on August 31, 2025, with a diagnosis of senile degeneration of the brain. R1's Care Plan initiated September 1, 2025, shows R1 has an activity of daily living self-care performance deficit related to dementia and anxiety disorder. The facility's State Report dated October 8, 2025, shows on October 7, 2025, a certified nursing assistant (CNA) was transferring R1 from her wheelchair to her bed with a one-person assist per her care-plan. After R1 sat on the edge of the bed, the CNA observed fresh blood on the floor and noted that R1 had a laceration on her right lateral leg. The wound care nurse (WCN) assessed the area and applied pressure to control the bleeding. Once the bleeding was controlled, further assessment revealed that sutures might be required to close the wound. Orders were obtained for evaluation and treatment in the emergency room. Investigation determined that the laceration occurred when R1 rubbed her leg again an exposed area of the bed frame during transfer. It was identified that a round cap was missing from the bed frame. R1's Skin and Wound Evaluation dated August 31, 2025, shows R1 had a laceration to her right lateral calf that measured 4.7 cm (centimeters) long, 2.0 cm wide, and a depth of 0.4 cm. R1's laceration was draining a moderate amount of bloody drainage. R1's local hospital record dated October 7, 2025, shows R1 was seen in the local emergency room for a laceration received during a bed transfer. R1's wound was sutured and cleaned, however due to significant leg swelling and lymphedema, fluid was noted to be oozing from the wound. R1 was given a dose of intravenous antibiotic and topical antibiotic. On October 14, 2025, at 10:43 AM, V4 Licensed Practical Nurse (LPN) said she was on break in her car when the certified nursing assistant (CNA) called her. V4 said that when she got into R1's room, V3 Wound Care Nurse (WCN) was already in there. V4 said she did not know what happened, but it happened during the transfer. V4 said the laceration was big and deep, so R1 got sent out to the local emergency room. At 11:07 AM, V6 CNA said she took R1 to the bathroom then transferred R1 back into bed. V6 said when R1 was sitting on the side of the bed, she noticed that R1's leg was bleeding. V6 said R1's nurse was on break, so she called V3 WCN to	S9999		

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S9999	Continued from page 2 come and assess R1's leg. V6 said R1's leg was "bleeding a lot". V6 said there was blood on the floor. At 12:27 PM, V3 WCN said she was the first nurse that assessed R1. V3 said there was blood on the floor and R1 was sitting on the edge of the bed. V3 said R1 shifted her leg and exposed the metal on the bed frame. V3 said there was a moderate amount of bleeding to R1's leg. V3 put a dressing onto R1's leg. V3 said R1's wound was too deep to take care of at the facility, so she sent R1 to the local emergency room. V3 said R1 received sutures to her leg. V3 said there was a small amount of blood on the metal part of R1's bed. V3 said there was a flat circle knob that was missing from the metal bed frame and V3 believed that is where R1 scratched her leg. V3 said she called V5 Maintenance Director. At 10:51 AM, V5 Maintenance Director said R1's bed was missing a round black cap. V5 said this was the first time he heard of the missing cap and replaced it. On October 14, 2025, at 10:02 AM, R1 was laying in her bed. There was a large triangle shaped wound to the outer part of R1's leg with12 blue sutures in place to this wound. R1 said the wound hurts "sometimes". The facility did not provide a polity documenting the facility checked the residents' beds on a routine basis. "B"	S9999		