

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER Crystal Pines Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 335 North Illinois Avenue Crystal Lake, IL 60014	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490</p> <p>Based on interview and record review the facility failed to ensure an alleged physical abuse was immediately reported to the administrator for 1 of 4 residents (R1) reviewed for allegations of abuse in the sample of 4.</p> <p>Findings include:</p> <p>R1's Face Sheet shows that he was admitted to the facility on [DATE].</p> <p>On 7/18/24 at 1:03 PM, V13 (R1's Family Member) said that about a month ago, R1 called her and said that he fell out of his wheelchair and a (specific race) male Certified Nursing Assistant (CNA) came into his room and reprimanded him and picked him up and pushed him against the wall and he fell again. V13 said that she went to the facility and spoke with the head nurse about the situation. V13 said, I told her exactly what I just told you. V13 said that V2 (Director of Nursing) left the room and came back about 15 minutes later and said that it did not happen.</p> <p>On 7/18/24 at 11:30 AM, R3 (who resides in the room next to R1) said that he heard R1 complaining about V7 (CNA) on 7/4/24. R3 said that he heard R1 yelling don't hit me, don't push me when V7 was in his room.</p> <p>On 7/18/24 at 9:21 AM, V5 (CNA) said that V7 (CNA) came to her about a week ago (verified it was 7/10/24) and asked her to go into the room with him to provide care to R1. V5 said that when she was in the room, R1 stated to her that V7 was evil and had pushed him.</p> <p>On 7/18/24 at 11:13 AM, V7 (CNA) said that on 7/4/24 around 3-4:00 PM, he went into R1's room because he noticed that his legs were hanging off of the bed. V7 said that he fixed his legs and R1 said to him that he hit him. V7 said that he told R1 that he did not hit him and went and told the nurse what had happened. V7 said that the nurse told him to not listen to R1 and to just leave him alone. V7 said that after that incident, he made sure that there was another staff member in the room with him when he went to provide care to R1.</p> <p>On 7/18/24 at 1:35 PM, V14 (Assistant Administrator) said that around 7/4/24, he and V2 (Director of Nursing) went into R1's room and spoke with R1 and V13 (R1's Family Member) about a fall incident. V14 said that initially, R1 told them that he was pushed into the wall by the CNA and fell. V14 said that in the same conversation, V13 said that she doubted that that happened.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/18/24 at 2:18 PM, V1 (Administrator) said that she is the abuse coordinator. V1 said that all allegations of abuse should be reported to her immediately even if the staff feel that they are not true. V1 said that if a resident says that a staff member pushed them and they fell , that would be an allegation of physical abuse and should be reported to me immediately and investigated. V1 said that she did hear from V2 and V14 about the fall incident on 7/4/24 but they never told her that R1 was alleging that a staff member pushed him and he fell .</p> <p>The facility's Abuse Prevention and Prohibition Policy revised on 1/24 shows, Resident abuse must be reported immediately to the Administrator. The facility administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action.</p>		