

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 01/08/2025
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39537</p> <p>Based on observation, interview, and record review the facility failed to ensure care was provided to a resident in a dignified manner for 1 of 3 residents (R3) reviewed for resident rights in the sample of 6.</p> <p>The findings include:</p> <p>On 1/8/25 at 10:12 AM, R3 was sitting up in bed. R3 said she had been on isolation for COVID. R3 said one night a CNA (Certified Nursing Assistant - V11) came in her room. R3 stated, I don't know her name, but I think [V1 - Administrator] knows it. I talked to her (V1) about it. Anyways, the CNA was changing me and I told her that I have pain in my knees and she needs turn me at pushing on my hips. She kept pushing on my legs and it hurt, so I was telling her not to touch my knees. She kept making comments that she had a headache and I was yelling. I wasn't yelling, but I was letting her know that she was hurting my legs. When she turned me, she made a comment about me being a very big girl. I know I'm overweight and I don't need to be reminded. I thought that was a rude comment. The CNA wasn't wearing a name tag, so I asked her what her name was and she told me, I don't have to tell you that. She never told me her name. I have the right to ask anyone who comes in my room to identify themselves. I just felt like she was terribly rude. The care was rushed, she wasn't listening to me, the fat comment, and then she refused to give me her name. I called the front desk and reported it to [V12 - LPN]. Then [V1 - Administrator] came to speak with me. [V1] told me that the CNA would not be coming back to the facility.</p> <p>R3's Face Sheet dated 1/7/25 showed she had diagnoses to include, but not limited to: polyosteoarthritis, generalized muscle weakness, COVID-19, lymphedema, history of cancer, obesity, irritable bowel syndrome, and schizoaffective disorder.</p> <p>R3's facility assessment dated [DATE] showed she was cognitively intact.</p> <p>R3's Psychiatry Initial Evaluation dated 12/3/24 showed, Resident reports being distrustful of unfamiliar staff. Recently experienced an episode of panic when evaluated by an unknown person .</p> <p>R3's Alteration in Pain Care Plan revised 4/17/24 showed, R3 has an alteration in comfort, pain associated with obesity, immobility, polyosteoarthritis, lymphedema and depression . Interventions: . R3 is able to: call for assistance when in pain, ask for medication, tell you how much pain she is experiencing, tell you what increase or alleviates pain .</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145257
		If continuation sheet Page 1 of 8

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's undated Investigative Summary showed on 12/29/24, R3 who is alert and oriented x 4 (to person, place, time, and situation) reported that a CNA on night shift did not speak to her respectfully. The agency CNA (V11) was not scheduled to return to the facility. According to the schedule the CNA was V11. This report showed R3 reported V11 was not wearing her name badge and refused to identify herself. R3 said V11 stated, I don't have to give you my name. R3 said V11 was very rude and made a comment about R3 being a big girl, during cares. The report showed R3 did not feel it was abuse, but it was rude and didn't want V11 provided further care for her.</p> <p>On 1/7/25 at 12:35 PM, V9 and V10 (CNAs) said the staff are supposed to wear their name badges at all times. V10 stated, They are part of our uniform. V9 and V10 said the agency staff rarely wear name tags. They said the facility had sticker name tags that can be filled out, when you forget your badge. They said if a resident asks your name, then you can't refuse to tell them. They said the resident's have the right to know who is providing care to them.</p> <p>On 1/7/25 at 3:11 PM, V3 (DON - Director of Nursing) said all staff should be wearing name badges at all times. V3 said the facility uses agency staffing for CNAs and nurses and there seems to be a problem with agency staff wearing a name badge. V3 stated, I've call [the agency] numerous times about their staff wearing name badges when working. The agency staff are always telling me they forgot it or they don't have one. It drives me nuts. We have sticker name badges at the Receptionist desk and they can write their name on it. There is no excuse to not have one. It is part of their uniform and they know it. If they don't wear a badge and a resident asks their name, then they should tell the resident their name. So the resident isn't afraid and knows that the person actually works here. This is the resident's home and they have the right to know who is providing their care.</p> <p>On 1/8/25 at 10:51 AM, V12 (LPN - Licensed Practical Nurse) said at the end of her shift on 12/29/24 she received a call from R3. V12 said R3 reported her CNA was very rude and mentioned something about R3's weight. The CNA (V11) said R3 was yelling at her, but R3 is usually pretty soft spoken. V12 said it was the end of the shift so, she and V11 (Agency CNA) were preparing to leave for the day. V12 said R3 reported V11 was very rude, so she notified V1 (Administrator). V12 said the agency staff rarely wear name badges. V12 said she's worked for an agency before and they provide you with a badge after you work a few shifts. V12 stated, There's no excuse for not having a name tag on. If you forget to wear yours, then we have sticker name tags at the front desk. V12 said V11 should have told R3 her name because the resident's have the right to know who is working. The surveyor asked V12 if a staff member should tell a resident they are a big girl during care. V12 replied, Absolutely not! That's rude and disrespectful. V12 said R3 is alert and oriented and able to make her needs known. V12 said the facility utilizes a lot of agency staff and it's hard to keep them straight. V12 said she isn't familiar with V11 and doesn't know how she interacts with residents.</p> <p>On 1/8/25 at 1:38 PM, V1 (Administrator) said on 12/29/24 was notified by V12 (LPN) that R3 complained that her CNA (V11) was rude during the night. V1 said R3 reported that V11 had been rude to her, wouldn't tell R3 her name, and commented that she was a big girl. V1 said all staff should be wearing name tags while working. V1 said there are disposable name tags available, so there is really no excuse. V1 said if a resident asks the staff's name, then they should provide it. The surveyor asked if V11 should have made the big girl comment to R3 during care. V1 replied, She absolutely shouldn't have made that comment. It's a dignity issue and no one wants to be treated that way. You should speak to others how you want to be spoke to. [V11] will not be returning to this facility.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Abuse Investigation file include an email to All staff dated 1/2/25 that showed, Please remember to always wear your name tag. Remember that this is our resident's home, and we must treat them with dignity and respect. Wearing your name tag ensures that they know who is providing care for them and helps them feel safe.</p> <p>The facility's undated Uniforms and Name Tags policy showed, .Name tags should be worn at all times when working in the facility so that our residents and families can easily identify our staff.</p> <p>The facility's undated Resident Rights' Policy showed, Your rights to safety and good care. Your facility must provide services to keep your physical and mental health, and sense of satisfaction with yourself, at their highest practical levels .</p>

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39537</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident's was free of misappropriation for 1 of 3 residents (R2) reviewed for abuse in the sample of 6.</p> <p>The findings include:</p> <p>On 1/7/25 at 10:13 AM, R2 was sitting up in bed with her cell phone resting on the overbed table, in front of her. R2 said on 12/28/24 she was taking a nap. R2 said she woke up and her cell phone was missing. R2 said she figured (V4 - Agency CNA (Certified Nursing Assistant) had it, but she wasn't sure. R2 stated, The first time she saw [V4] was 4 days before. She (V4) asked me if she could use my phone and I gave her permission that day, but she used it in front of me. Then she came back on 12/28/24 and asked me if she could use my phone. I told her no a few times. When I woke up from my nap, my cell phone was gone. I called the CNA to report my cell phone was gone and she looked all over the place. They looked and looked and couldn't find it. I told the CNA (I don't remember her name) that V4 had it. I knew she took it. The CNA told me they couldn't find [V4]. Then the nurse (V5 - RN) came in and asked me if I gave [V4-CNA] permission to take my phone and I told him I did not. At some point they called the police. I didn't want to get that girl (V4) in trouble. She seemed like she may of had something wrong with her, like bipolar or something and I didn't want her to get messed up with the law. Everyone deserves a second chance. Then [V4] came back in room and the nurse was telling her she had to leave. She was standing over here in this corner (pointed to the corner, near the window on the far side of the resident room and to the right of R2's bed). She was moving around like she was trapped or something. She insisted that she had to use my phone again to punch out. I guess she put some app (application) on there. The nurse told her she couldn't use my phone and she needed to leave, but she picked up my phone again and said she removed the app. It was a wild situation. Then the police came and checked my phone. They said it looked like she made several phone calls, but I didn't want to press charges. It wasn't right what she did, but I don't want anyone to get wrapped up with the law. The surveyor asked if R2 had any personal information on her cell phone. R2 replied, It's my daughter's old phone, so I'm not sure. I don't know what's on there. I know my daughter was worried about that. It was so wild, [V4] didn't even try to deny she took my phone without permission. It seemed like she didn't understand what she did was wrong. I feel sorry for people that have disability. I guess I'm just too trusting. I didn't know all that information can be stored in a phone. If she (V4) was such a crook, then why did they hire her?</p> <p>R2's Face Sheet dated 1/7/25 showed diagnoses to include, but not limited to congestive heart failure, generalized muscle weakness, major depressive disorder, chronic pain syndrome, lymphedema, COPD (Chronic Obstructive Respiratory Disease), and morbid obesity.</p> <p>R2's facility assessment dated [DATE] showed she was cognitively intact.</p> <p>R2's progress notes were reviewed and did not contain any notes regarding this incident.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's undated Investigation Summary showed, R2 was alert and oriented x4 (to person, place, time, and situation). This report showed that V5 (RN) reported that V4 (Agency CNA) took R2's phone (without permission) and used R2's cell phone in her car. This report showed V4 (Agency CNA) admitted she had taken the phone, but she had returned it. This report showed that V5 educated V4 (Agency CNA) that she was not allowed to take resident's belongings for any reason. This report showed V4 replied, everything is okay now. This report showed that the police were called and V4 (Agency CNA) was escorted out of the facility (and was not allowed to return to the facility). R2 reported that she awoke from a nap and noticed her cell phone was missing. R2 reported she knew V4 was working and thought V4 took her phone.</p> <p>The facility's Abuse Investigation file for R2 include an email to All Staff, dated 1/1/25 that stated, Under no circumstances is it allowable to use a resident's personal belongings: including but not limited to cellphones. Under no circumstances should a resident's cell phone be used by staff to make calls, access apps, or send texts for their own personal use.</p> <p>On 1/7/25 at 3:11 PM, V3 (DON) said she was not present the day V4 took R2's cell phone, but she received a phone call from V7 (ADON). V3 said V7 reported V4 went into R2's room, took her cell phone (without permission) and used R2's cell phone in the parking lot. V3 stated, I couldn't believe it? How did she (V4) think it was acceptable to do that? I was on the phone with [V7-ADON] and could hear the Agency CNA's (V4) crazy answers over the phone. Apparently [V4] downloaded her agency staffing app onto [R2's] phone and used the phone in her car. She (V4) didn't seem to see anything wrong with that. She (V4) only worked here one other day and that was it. I DNR'd (Do Not Return) her from the facility. The resident's cell phone is their personal property and the staff should never ask to use their phones for any reason. We have computers and phones at the facility. She shouldn't have done that. It's unacceptable.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/8/25 at 10:27 AM, V5 (RN) said he worked 12/28/24, when the Agency CNA (V4) took R2's cell phone. V5 stated, [R2] reported to me that she didn't give (V4) permission. When I left [R2's] room CNAs (unable to recall their names) approached me and told me the same thing. I had already been having issues with her (V4) staying in the building that shift. She kept going in and out of the facility or in the break room and I was having a hard time keeping track of her. I told her (V4) that she had to remain near her assigned unit. Then this happened. I found [V4] and asked her if she took [R2's phone] and she admitted she took the phone. I told her that she isn't allowed to do that and V4 stated, I gave the phone back, everything is okay now. I guess the resident had let (V4) use her phone once before. Then V18 (R2's family member) called the facility and she had been trying to call [R2]. V5 said V7 (ADON - Assistant Director of Nursing) was the Manager on call that weekend, so he notified her. V5 said V18 (R2's family member) was concerned that V4 accessed private information in R2's phone. V5 said at some point the police were called and V7 (ADON) told him to escort V4 out of the building. V5 said he told V4 she had to leave and she started acting squirrely, and said she had to take her work app off R2's phone. V5 said V4 went in R2's room and picked up R2's phone again. V5 said he repeatedly told V4 that she was not to touch R2's phone and the facility would take care of her punch out with the agency. V5 said R2 told him V4 did not have permission to download an app on her phone. V5 said he finally got V4 (Agency CNA) out of R2's room and walked her to the lobby, but V4 was refusing to leave and demanding to be paid on the spot. V5 said he tried to explain the process to V4, but she said he was stalking her. V5 said he explained that was not the case, but he had to ensure she left the facility. V5 said he got a phone call from at the front desk and at that point V4 (Agency CNA) took the opportunity to leave the building. V5 said V4 sat in her car, in the parking lot for a while, but left when the police came. V5 said the police met with R2 and looked at her phone. V5 stated, She (V4) really didn't think there was anything wrong with it. It was crazy. I've been a nurse for a long time and I've never seen anything like it.</p> <p>On 1/8/25 at 10:36 AM, V6 (Restorative Aide) said V5 (RN) asked her to go with him to escort an Agency CNA (V4) out of the building. V6 said V5 (RN) told V4 (Agency CNA) that you can't touch R2's cell phone, but she did it anyway. V6 said V4 just went by R2's bed and grabbed the cell phone. V6 said R2 didn't give V4 permission. V6 said V4 (Agency CNA) was concerned with clocking out, on the staffing app that she had downloaded on R2's phone. V6 said V5 was telling V4 that the facility would handle her clock out, but V4 wouldn't listen. V6 said V4 (Agency CNA) said to R2, You let me use it before, and R2 replied, I did then, but not today. I told you no. V6 said the facility staff should never use a resident's cell phone for personal use. V6 stated, It's a known rule that we don't use any of the resident's belongings. That belongs to the resident. I don't know how she (V4) thought it was okay.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/8/25 at 11:14 AM, V7 (ADON) said she was on call 12/28/24 and V5 notified her that V4 (Agency CNA) took R2's cell phone without permission. V7 said V5 told her that R2's family was upset and wanted to talk to management. V7 said V18 (R2's family member) had called R2's cell phone numerous times and R2 did not answer, but finally R2 answered her phone and told her that V4 (Agency CNA) took her phone. V7 said V18 (R2's family member) was concerned about the possibility of V4 (Agency CNA) tried to steal banking information or personal information from R2's phone. V7 said it's unacceptable for staff to take anything that belongs to the resident. V7 said V5 (RN) reported that V4 (Agency CNA) kept disappearing and was difficult to keep track of. V7 said V4 returned R2's phone and didn't seem to think she did anything wrong, then she went back and grabbed R2's phone again because she needed to clock out and delete the staffing app. V7 said V5 (RN) was able to get V4 (Agency CNA) out of R2's room, then V4 started calling the on-call phone. V7 said V4 called from a different number, so she obviously had access to a cell phone. V7 stated, [V4] kept stalling and it didn't seem right. The police told us to detain her, but we're not allowed to do that. She eventually went out to her car, but she sat out there. She didn't leave until the police came. The facility has phones and computers that she could have used. There is no reason for her to be asking a resident to use their phone. She (V4) only worked here 1 other day and didn't even make it through half of that shift. It's crazy that it happened, then she refused to leave and demanded to get paid. It's all just crazy.</p> <p>On 1/8/25 at 12:50 PM, V18 (R2's family member) said on 12/28/24 she attempted to call R2 10+ times. V18 said someone picked up, but would hang up the phone. V18 said she was getting concerned, then R2 finally picked up and was yelling, She stole my phone. V18 said R2 told her that V4 (Agency CNA) had asked to use R2's phone multiple times on 12/28/24, but R2 said No. V18 said R2 said she took a nap and when she woke up her phone was gone. V18 stated, That's when I called the facility. V18 said she works in the industry and knows what should be done in this time of situation. V18 said she told the facility to handle it or she would. V18 said the police checked R2's phone and told her that V4 made several phone calls and attempted to access a cash app on her phone. V18 said she has passwords protection in place, so V4 was not able to get any money. V18 said the police told her that they called the numbers V4 (Agency CNA) had called and she was asking them for money. V18 said R2 is too trusting and believes everyone deserves a second chance. V18 stated, I tried to explain to her what information is on cell phones and that she (V4) had attempted to access my money. [R2] doesn't like that V4 (Agency CNA) had to be involved with the police, but I explained that we were aware enough to stop it before she got anything, but she may get away with it for other unsuspecting, vulnerable people.</p> <p>On 1/8/25 at 1:38 PM, V1 (Administrator) said there was no doubt that V4 (Agency CNA) took R2's phone, used it in her care, and made personal phone calls. V1 said she had no idea why V4 downloaded her staffing app onto R2's phone. V1 stated, It's completely inappropriate. We have computers and phones at the facility. She could have borrowed a co-worker's phone. She shouldn't have used the phone PERIOD, EVER. V1 said she it's clear that R2 doesn't understand how much personal information is contained in cell phones now. V1 stated, That was the daughter's concern too. The surveyor asked if she knew V4 had attempted to access cash apps on R2's phone. V1 replied, I did not know that. In hindsight, I should have substantiated (misappropriation).</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Abuse, Prevention and Prohibition Policy revised 1/2024 showed, Statement of Intent: Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse to anyone, including, but no limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members, or legal guardians, friends, or other individuals. Policy: The facility prohibits mistreatment, neglect, or abuse of residents . The facility also prohibits misappropriation of resident property. The residents must not be subjected to abuse by anyone. The facility will educate all employees upon hire and at least annually of the definitions of the Abuse Prevention and Prohibition Policy including definitions pertaining to abuse and neglect . Definitions: . Misappropriation of Resident Property is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent .</p>		