STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145257	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Pines Rehab & Hcc	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)
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** 39537 Based on interview and record review the facility failed to perform thorough pressure ulcer assessments and initiate a baseline care plan for a resident admitted to the facility with a pressure ulcer for 1 of 1 residents (R1) reviewed for pressure ulcers in the sample of 4. Findings include: R1's Facesheet dated 4/24/25 showed she was admitted to the facility 10/28/24 with diagnoses to include, but not limited to: COVID-19, generalized muscle weakness, hypothyroidism, diabetes, gastro-espophageal reflux disease (GERD), unspecified cirrhosis of the liver, and gout. R1's Nursing Admission Assessment completed dated 10/28/24 showed she had pressure to her sacrum. This document did not provide any further description or measurements of R1's pressure ulcer to her sacrum. R1's Progress Notes did not contain a detailed pressure ulcer assessment for R1's initial pressure ulcer and weekly assessment. R1's Electronic Medical Record (EMR) did not contained a thorough initial or weekly assessment of R1's pressure wound to her sacrum. R1's Skin Check Weekly dated 10/28/24 showed R1 had an open area to her sacrum, but there was no further assessment of the wound (i.e. measurements, appearance, wound bed, wound edges, drainage, etc.) R1's Physician Order Sheet dated 4/24/25 showed there was an order for a wound care consult dated 10/28/24 and orders for wound care to the scarum dated 10/28/24. R1's Skin Integrity Care Plan wasn't imitated until 11/4/24 (8 days after admission) and the related to details were not completed. This care plan showed interventions to include: Evaluate wound for: Size, Depth, Margins: peri-wound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene. Document progress in wound healing on an ongoing basis. Notify physician as indicated. (continued on next page)

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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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/25 at 1:43 PM, V7 (Registered Nurse - RN) said the floor nurse completes an admission assessment on all new admits. V7 said the wound care process had changed about a month ago. V7 said in October 2024 the floor nurse would do an initial skin assessment and chart any findings. V7 stated, If there was a wound, then the nurse should describe it to the best of her ability. Now we don't stage pressure wounds and we have to notify the Wound Care Nurse (WCN). The WCN will complete a detailed assessment. The floor nurse should provide measurements, location of the wound, and a basic description of the wound and any drainage. (The surveyor directed V7 to review R1's Admission Assessment and asked what R1's wound looked like.) There is no way to know what it looked like because it just says pressure. (The surveyor asked V7 if she saw any detailed Wound Assessment for R1's sacral pressure wound.) I don't see anything here. V7 said proper documentation of the wound assessment is an important for tracking the wounds progress and ensuring continuity of care for the R1. V7 said she is unsure who initiates the baseline care plan for residents. V7 stated, I think MDS (Minimum Data Set) does that? I really can't speak on it. I don't remember every doing that. On 4/25/25 at 2:00 PM, V4 (WCN) said she started with the facility around the third week of February 2025. V4 said she was not working at the facility when R1 was there. V4 said all new admissions should have an initial skin assessment. V4 said if it is during them week, the nurse will notify her if there is a wound and she usually does a thorough wound assessment within 24 hours. V4 said the floor nurse can provide a basic description, including the location, size, appearance of the wound and if there is any drainage. V4 said the initial wound assessment is important to track the wounds progress, determine if the treatments regimen needed to be altered, and to prevent the risk of infection. The surveyor showed V4, R1's Admission assessment dated [DATE] that showed, pressure, to the sacrum and R1's Skin Assessment Weekly dated 10/28/24 that showed R1 had an open area to her sacrum. The surveyor asked V4 if R1's documentation provided the proper assessment details of a pressure wound. V4 replied, Absolutely not. The baseline assessment is very important, so everyone knows the starting point. V4 said a proper wound assessments includes: measurements; location; description of the wound bed and wound edges; staging for pressure ulcers; and a description of drainage. V4 said if R1 had a pressure wound on admission, then R1 should have had a baseline care plan initiated within 24 hours to address R1's individualized care needs. V4 said the Care plan is a tool to communicate the R1's care needs to the care team. On 4/25/25 at 2:21 PM, V2 (Director of Nursing - DON) said she did not recall R1, but she was looking through R1's record for Skin Assessments. R1 provided the Skin Assessment Weekly dated 10/28/24 (showing an open wound to R1's sacrum, but no further description of the wound). V2 said there should be a detailed initial pressure ulcer assessment and weekly pressure ulcer assessment. V2 said based the information documented, there was no way to know what R1's sacral pressure ulcer looked like. V2 said the facility does not use shower sheets and she had reviewed all the possible places the nurse should have documented a thorough wound assessment. V2 said she could not locate one. V2 said a baseline care plan should be initiated within 24-48 hours of admission. V2 said R1's Admission Assessment showed she had pressure to her sacrum, so R1's care plan should have reflected there was a skin integrity concern. V2 stated, I do see a wound care consult ordered. There isn't usually a Wound Care consult unless the resident had a wound. The whole thing is very confusing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Pressure Injury Assessment and Treatment Policy dated 1/2025 showed, The purpose of this procedure is to provide guidelines for a consistent method of identification of and for the initial care of identified alterations in skin integrity, pressure injuries, and the prevention of acquiring additional alterations in resident skin integrity . General Guidelines: A. The pressure injury treatment program should focus on the following strategies: a. Evaluating the resident, understanding current risk level, and/or the status of existing skin alteration and/or pressure injuries .Documentation: The following information should be recorded in the resident's electronic medical record. A. Document type of wound and location: a. Stage of the wound in pressure. b. Use anatomical location in description. B. Partial thickness or Full thickness. C. Wound measurements: a. Head to toe (Length). b. Left to right (Width). c. Depth. D. Undermining, tunneling, or sinus tract: a. Clock method (12 o'clock represents residents head, 6 o'clock represents resident's feet. E. Exudate (Drainage): a. Type. b. Color. c. Amount. d. Odor. i. Absence or presence of odor and describe the smell. F. Wound bed: a. Adherence of tissue (slough or eschar). b. Types of tissue visualized in wound bed. c. Amount of visible tissue: i. Describe in percentage amounts tissue types that make up the wound bed. ii. Can you use the clock system to describe location of varying tissue types. d. Debris or foreign bodies. G. Describe wound edges: a. Definition (defined or undefined). b. Attachment. c. Border shape. d. Maceration, epibole, fibrotic, callused etc. H. Describe Peri-Wound (Surrounding tissue). I. Describe any indications of possible infection. J. Pain: a. Causative factors. b. Duration. c. Intensity. d. Intervention for pain relief and effectiveness. K.Document interventions for healing .