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	10/14/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a residents bed was maintained to ensure no hazards were present for one of three residents (R1) reviewed for injury in the sample of three. This failure resulted in R1 experiencing a large skin tear from exposed sharp metal on the bed, requiring R1 being sent to the local hospital and requiring 12 sutures to the wound.Findings include:R1's Face Sheet dated October 14, 2025, shows R1 was admitted to the facility on [DATE], 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 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.