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	04/20/2026

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. Based on interview and record review the facility failed to safely transport a resident. This failure resulted in R1 falling from her wheelchair during the transport and sustaining a 5 centimeter (cm.) laceration to her forehead requiring emergency medical attention, 11 sutures and hospitalization. This applies to 1 of 3 residents (R1) reviewed for safety in the sample of 4. This past noncompliance occured from 3/16/26 to 3/23/26. Findings include: R1's face sheet shows R1's diagnoses including Alzheimer's Disease, muscle weakness, and a non-displaced type 2 dens fracture.R1's current care plan shows R1 is at risk of falls and requires staff assistance with toileting and transfers. R1's nursing progress note dated 3/16/26 at 9:12 PM, shows that R1 had a fall out of her wheelchair while being taken to the bathroom by a CNA (Certified Nursing Assistant). R1 fell forward out of her wheelchair and hit her face on the floor. A laceration was noted above R1's left eyebrow, 911 was called and R1 was sent to a local emergency room for treatment.A State Reportable Incident form completed by V2 (Director of Nursing) shows on 3/16/26 after the fall, R1 was transported to the emergency room and admitted for further diagnostic testing. R1 sustained a laceration to her left eyebrow requiring sutures. There was also a fracture to her C2 (odontoid) however imaging was unable to determine if this was a new or old fracture. The report shows that R1 propels herself in the wheelchair without footrests therefore footrests were not in use at the time of the fall. R1's History and Physical from a local community hospital shows R1 required sutures to her forehead laceration, and R1 had a prior C2 fracture in November 2025. The report shows a CT scan was done and states, Type II fracture of the dens with slight posterior displacement and slight posterior angulation. The fracture margins are somewhat indistinct, suggesting a nonacute fracture. R1's emergency room report shows 11 sutures were needed to close the laceration above R1's left eyebrow.R1's Electronic Medical Record (EMR) shows R1 returned to the facility on 3/21/26 with a cervical collar in place and sutures to her left forehead. On 4/20/26 at 9:56 AM, V2 said she completed an investigation of R1's fall and they determined during a root cause analysis that the cause of R1's fall was because R1 she did not have footrests on her wheelchair while being transported to the bathroom. R1 was told to hold her legs up while V3 pushed her but suddenly she put her feet down on the floor during the transport causing her to fall forward out of the chair. V2 said R1 propels herself around without footrests on her wheelchair at baseline but when staff are going to transport residents, they should put the footrests on prior and the CNA (V3) did not do so. V2 said R1 needed sutures after the fall, and the hospital could not determine if R1's C2 fracture was new or a previous one. On 4/20/26 at 10:10 AM, V3 (CNA) said I was pushing her (R1) in a wheelchair without her footrests on. It happened so fast and next thing I knew she was on the floor. I was going to toilet her. We should transport residents with footrests on their wheelchairs. I should have put the footrests on first, we were in- serviced right after making sure we put on the footrests.On 4/20/26 at 11:11 AM, V11 (Physical Therapist) said before residents are transported the staff should put footrests on wheelchairs, not all residents can hold their feet up that long.On 4/20/26 at 11:38 AM, R1 was sitting in her wheelchair by the nursing station with a neck collar on. R1 said, I had quite a fall yes, I don't remember a whole lot after, but I was being pushed to the bathroom by a CNA and I fell forward and out of the chair. I had a cut to my (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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(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	forehead and got sutures.The facility provided Skilled Fall Policy dated 5/2025 states, Each resident residing at this facility will be provided services and care that ensures that the resident's environment remains as free from accident hazards as is possible and each resident receives adequate supervision and assistive devices to prevent accidents.Prior to the survey date of 4/20/26 the facility had taken the following action to correct the noncompliance.1. On 3/17/26 the facility Interdisciplinary team held a Root Cause Analysis meeting and immediately began a plan of correction after reviewing R1's fall. The facility informed R1's physician and Medical Director immediately. A comprehensive review of policies and interventions to be included were discussed.2. On 3/17/26 all facility staff that transport residents in wheelchairs were educated and in-serviced regarding footrests and transporting residents.3. R1's Care Plan was immediately updated. And she was re-assessed by Physical Therapy.4. All residents were audited for their need for footrests. And V2 did weekly audits for 4 weeks and then on-going monthly audits for 2 months to ensure staff are complying with residents safety interventions.5. All staff were in-serviced and the plan of correction date when the facility was in compliance was identified as 3/23/26. 6. Audit results were brought to the QAPI meeting on 4/14/26 and no new compliance was found.