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	05/06/2026

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 0693 Level of Harm - Actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on interview and record review the facility failed to ensure an enteral feeding was administered as ordered 1 of 3 residents (R1) reviewed for enteral feedings in the sample of 3. This failure resulted in R1's admission to the acute care hospital for treatment of aspiration pneumonia.The findings include:R1's face sheet showed she was admitted to the facility 9/24/2020 with diagnoses to include hypokalemia, dysphagia, gastrostomy status, gastrointestinal hemorrhage, chronic obstructive pulmonary disease, major depressive disorder, and anxiety disorder. R1's 6/26/25 facility assessment showed she had severe cognitive impairment, was dependent on staff for all cares, and had a feeding tube.R1's July 2025 Physician Order Sheet showed an order started 4/18/25, Enteral Feed Order: in the evening. Administer Novasource via PEG-tube at 60 cc/hr. On at 6:00 PM off at 6:00 AM. Total volume to be infused 720cc in 24 hours. May turn off for short periods of time for care and services. Verify total volume infused prior to turning off.R1's Care Plan initiated 11/29/23 showed, [R1] requires Enteral Feeding via PEG tube. The resident will be free of aspiration through the review date (revised 8/20/25) . The resident id dependent with tube feeding and water flushes. See MD (physician) orders for current feeding orders.R1's 7/29/25 Physician Note entered by V13 (R1's Physician/Facility Medical Director) showed, Date of Service: 7/29/25; Visit Type: Acute. Chief Complaint: I was requested to see the patient for being given bolus feeding accidentally last night. History of Present Illnesses. She has been on continuous tube feeding, she was given bolus feeding accidentally last night. She seems to have mild congestion indicating possible aspiration. She was given bolus tube feeding early this morning and last night. She did not show any vomiting. She seems congested with some rales. Will resume tube feeding when she's stable.The facility's incident report for R1 dated 7/28/25 at 10:00 PM and entered by V10 (nurse) showed, . Received shift report from nurse. She stated she was having a problem with tubing. Checked on resident around 12:05 AM, vitals were stable. Earlier in the morning, resident had two small emesis. I noticed tube feeding was in different bag and disconnected. Was not sure if resident received correct feeding per orders. Notes: . On 7/28/25, nursing staff reported concerns regarding the resident's tube feeding set up. Later, during the night shift, the resident's tube feeding was found in a different bag and disconnected. The resident remained stable throughout the shift, and vitals were within normal limits. She did have two small emesis'. The incident was reported to DON, and the provider was notified.On 4/22/26 at 11:12 AM, V11 (R1's son) said, On 7/28/25 there was an issue with a tube feeding. This issue was brought to my attention when I came into the facility on the morning of 7/29/26. Even before I went into her room, I was pulled aside by the nurse (V5 Registered Nurse) who told me my mom was overfed, but she didn't know how it happened. she said she didn't know what happened but heard about it from the overnight nurse. Then the CNA (Certified Nursing Assistant) said something was wrong with mom, she took her to the shower, and she started to vomit, which was not like her. The CNA apparently found out through other staff that something happened with her feeding. The nurse used the term overfeeding . when I came in it was a bit alarming because as she was lying in bed and she was vomiting a little bit, gagging, and choking. I never could get quite down to the bottom of it. She went to the hospital the next day when she started to develop a fever and a bad cough with congestion. She (continued on next page)

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
	145257	A. Building B. Wing	05/06/2026

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 0693 Level of Harm - Actual harm Residents Affected - Few	became very lethargic and unresponsive. There was a Nurse Practitioner who came in because I said, ?hey, she aspirated because of this overfeeding' and he said he hadn't heard about that. when he had seen her, she was still pretty with it. when watching the videos from her room I saw the CNA say they fed her 2 times too much, or 2 times too fast. The wound nurse is the one who identified that her blood oxygen was starting to tank. They put her on oxygen, and shortly thereafter, they called 911 to get her to the hospital. When she was admitted to the hospital they called [the facility] and they told the hospital she was overfed. when I walked in that morning, there was new kind of pump in the room . it was different than they had ever used with my mom. I later learned there was confusion with the staff as to how to use that pump. I guess they weren't clear on setting the rate. When I walked in the room, the rate was set two times faster than what they normally did. Apparently one of the nurses thought this pump had an automatic flushing system in it and she tried to program it automatically flush the system as well. After this incident, she had an ongoing cough and obvious issues after that aspiration episode where her breathing wasn't good and after that she had to be on oxygen concentrator. I had continuous recording in her room, signs were posted at the door. I sent all the video and recordings about this incident. I think the information in these videos is pretty compelling. R1's Change of Condition form dated 7/29/25 entered at 4:34PM showed, The resident is experiencing a change in condition. See SBAR assessment for further information and family/physician notification. The change in condition the resident is currently experiencing is nausea, vomiting, chills, labored breathing, use of accessory muscles, diminished sounds at the bases. sputum bright yellow in color. HOB (head of bed) elevated Tylenol and Zofran (for nausea) given relief noted.R1's 7/30/25 Progress Note entered by the V15 (Nurse Practitioner) showed, Date of Service: 7/30/25; Visit Type: Acute. Chief Complaint: the patient was found in their room exhibiting signs of respiratory distress, with oxygen saturation below 80% on room air. Supplemental oxygen was administered, but it remained difficult to maintain saturation levels above 90%. A significant deterioration in the patient's medical condition was observed this morning. Decided to transport the patient to hospital for further evaluation and treatment.R1's Encounter Note entered by V15 (Nurse Practitioner) showed, the nurse reported that the patient is admitted to the hospital and diagnosed with aspiration pneumonia and a urinary tract infection.R1's Acute Care Hospital Documents dated 7/30/25 at 10:45AM showed, . Emergency Department Encounter. Chief Complaint: . cough, congestion, Patient comes from [the facility] and son has concerns she was overfed via her g tube and aspirated yesterday, patient has audible congestion. History of Present Illness: . Shortness of breath. fever. presents to the emergency department with cough, congestion, hypoxia, fever. Patient's son provides the history. Notes that the patient was accidentally given her tube feed as a bolus yesterday rather than over a 12- hour infusion, the staff noted that she was vomiting afterwards. Since then, patient has had significant cough and chest congestion. She was hypoxic at the facility, does not use oxygen at baseline. She has significant rhonchi and a congested cough. She is tachypneic and using accessory muscles to breathe. requested pulmonology consultation.R1's Acute Care Hospital Documents dated 7/30/25 at 2:58 PM showed, . History and Physical. Chief Complaint: Shortness of breath, hypoxia, nausea and emesis at skilled nursing facility after receiving bolus tube feed. The patient is unable to provide any history whatsoever due to previous CVA (Cerebrovascular Accident), so the history is obtained from my discussion with the emergency medicine physician. The patient was at her skilled nursing facility yesterday, when she was accidentally given bolus tube feeding instead of continuous infusion tube feeding. The patient apparently developed nausea and vomiting after receiving the bolus tube feeding. Today, the patient was noted to have cough and chest congestion and was hypoxic on room air, so the facility staff called 911. Assessment and Plan: Suspected aspiration pneumonia, with history of severe tracheobronchomalacia noted on previous CT scan. History of CVA with baseline dysphagia, status post G-tube placement, and probable dementia, with suspected aspiration at skilled nursing facility.R1's Acute Care Hospital Documents showed, . Pulmonary Inpatient Note. Chief Complaint. Cough, congestion, fever, shortness of breath. Presenting to the hospital 7/30/25 with cough, (continued on next page)

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	05/06/2026

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 0693 Level of Harm - Actual harm Residents Affected - Few	congestion, shortness of breath, fever. Patient resides at [the facility]. Patient was accidentally given her tube feed as a bolus yesterday and she started vomiting after. Since emesis episode, has ha a cough, congestion, lethargy. Assessment/Plan: Aspiration event, fever, aspiration pneumonia, tracheobronchomalacia.R1's 8/4/25 Physician Note showed, Date of Service: 8/4/25; Visit Type: History and Physical. Chief Complaint: I saw the patient for re-admit H & P (history and physical). She has been awake this morning, weak and confuse as she usually does early in the morning. She admitted to the hospital 7/30/25-8/2/25. She has been on continuous tube feeding, she had a bolus tube feeding accidentally instead of continuous feeding. She developed congestion, SOB (shortness of breath), and hypoxia O2 saturation 60%, required O2 per nasal cannula, later that day; she was taken to ER and found to have aspiration pneumonia. This was treated with intravenous antibiotics, and she tolerated low oxygen per nasal cannula. She was stabilized and discharged back to our rehab on continuous tube feeding.On 4/22/26 at 12:19 PM, V10 RN (Registered Nurse) said, What I remember from that is that the previous nurse had some confusion finding the tubing. The previous nurse had used the bag and I guess you can program it one bag for water and one for tube feeding I think she set it up that way. It was set up already. If I remember right the tube feedings ran through my whole shift. I wouldn't start it or end it. I think the machine was programmed to end, so I would just disconnect it after the machine ended. I remember she had one or two emesis. I saw one emesis, it looked like tube feeding.On 4/22/26 at 1:10 PM, V8 CNA (Certified Nursing Assistant) said, We did have some problems. Something happened the night before. I remember that her tube feeding was an oopsie, where she got her tube feeding too fast which caused her to be sick. I don't know if it was the nurse, like if it was an agency nurse, or someone that wasn't really familiar with her. she had the g-tube, but she could have orange juice, apple sauce, pudding, just for enjoyment, she would never eat a large quantity of it.On 4/22/26 at 1:19 PM, V9 CNA (Certified Nursing Assistant) said, I remember hearing that she got too much tube feeding. I don't know what happened on nights and evening shift. She was vomiting up stuff.On 5/6/26 at 10:11 AM, V15 (Nurse Practitioner) said, It was reported to me that she had been given bolus feeding accidentally. The level of risk for the patient depends on the amount of bolus feeding. If it was a small amount, it isn't as big of a deal, but the patient was not in the best condition at the time. We know that the patient was vomiting right after the bolus feeding. They should follow the order for it. It should be given as the order shows. That is why they follow the order, because of the risk of aspiration.On 5/6/26 at 11:21 AM, V2 DON (Director of Nursing) said, I know coming in that day, there was a big commotion because [R1's] son was there, and he was really mad. He had been talking to [V10], the night nurse. He was yelling at [V10]. I told him I didn't know what was going on, I would have to see. I started my investigation. At this particular time, [R1] was getting her feeding through the pump, it wasn't bolus. The nurse went to go get a bottle of feeding that has spikes to spike the bottle and it is hung right from the bottle. The nurse said she couldn't find the tubing that had the spike, so I had seen in there, there were two bags hung, one with tube feeding and one with water in it. She found the one with the two bags, so she put the feeding in the bag. She got a plain bag and put the tube feeding from the plastic bottle, and she put it in the bag. I talked to V6 and V10. I wanted to know how it was flushed. V6 and V10 both said they flushed it manually through the tube, because V10 had flushes to do on night shift and V6 had some to do on PMs. I showed [V6] where the supplies were and she said ?oh okay'. I did a skill's check on her, because I wanted to know that she could do it. I didn't look at the pump when I came in because it was stopped already. we had a meeting with the son, and I said I was going to educate the nurse on the whole process and supplies. [V10] called me in the morning to report it and I told him to put it in risk management. [V10] must have entered the time he came on shift as the risk management time because he didn't call me at 11:00 PM, he called me in the morning. When asked about what conclusion she came to during this investigation, V2 said she was trying to figure out [V10's] whole part in this situation. V2 said she spoke with V6 five times because she is hard to understand. V2 said she can't say [R1] did or didn't receive it the feeding correctly. It was already disconnected in the morning, so I was just trying to (continued on next page)

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	05/06/2026

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 0693 Level of Harm - Actual harm Residents Affected - Few	piece it together.On 5/6/26 at 10:58 AM, V13 (Physician/Medical Director) said, I remember this bolus feeding was given accidentally. It was supposed to be a rate feeding. people on rate feeding should not be given bolus feedings, bolus feeding is for someone who has no dysphagia or reflux. Bolus is not given to those people with dysphagia, so they give them a rate feeding (slower feed) to avoid reflux. The logic is that reflux causes aspiration pneumonia. Symptoms from receiving a bolus feeding instead of a rate feeding would include coughing, shortness of breath, vomiting (reflux), and that can cause aspiration pneumonia. [R1] was increased risk for aspiration.The facility's policy and procedure related to enteral tube feedings was requested. The facility provided a Skills Checklist titled Enteral Tube Feeding via Gravity which showed, . Check the enteral nutrition label against the order before administration. Add the following information: Resident Name, Type of Formula, Date and Time Formula was prepared, Rate of Administration (ML/HR). Check the order to verify the type, amount, method, and rate of administration.