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	06/11/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident was free from misappropriation of property for 1 of 3 residents (R1) reviewed for abuse in the sample of 3. This past non-compliance occurred from 5/11/26 to 6/10/26.The findings include: R1's admission records shows he was admitted to the facility on [DATE]. R1's quarterly resident assessment and care screening dated 4/23/26 documents he was cognitively intact. R1s progress notes for 5/22/26 document he expired in the facility.On 6/11/26 at 9:00 AM, V1 (Administrator) said he was informed by a staff member on 6/4/26 a local restaurant employee had informed him of a staff member possibly using a resident's credit card. He said V4 (R1's nephew) had called the restaurant inquiring about receipts he had found going through paperwork. On 6/11/26 at 10:30 AM, V4 (R1's nephew) said when he was going through R1's papers he found receipts from a local restaurant dated 5/11/26. One receipt had charges for $58 and included shrimp dinners and 4 beers. Which he found odd considering (R1) did not drink. Then later in the same day there was another receipt for more shrimp and more beer. V4 said he called the restaurant to see if they could identify who charged the meals. The staff said they knew who it was, she was a regular [NAME]. V4 said he did not know about any of the charges until after (R1) passed, so he was unable to verify any further details.On 6/11/26 at 10:20 AM, V5 (Cook) said he had received a call from an employee/family friend at a local restaurant about a resident family member inquiring about receipts and the use of a credit card. V5 said he immediately reported the incident to the administrator. On 6/11/26 V1 said after he received the reported allegation, he spoke with the manager at the restaurant and learned R1's credit card had been used to purchase food. They identified V3 as the employee using the card. V1 said V3 said R1 had authorized her to use the credit card to get him some food and something for herself. V1 said this is something the facility does not allow. We can assist residents, but staff are not to perform financial transactions. V3 admitted to buying food for herself and also paying for ride share [NAME].On 6/11/26 calls and messages to V3 were not returned. In a written and signed statement, V3 reported R1 wanted food from the restaurant and let her use his card to purchase food. She bought food for herself and couple drinks and bought him some shrimp. She took the food to R1 the next day and paid him back the money. She also used the card to pay for ride shares.The 5/11/26 receipts show a purchase at 2:10 PM for $56.66 for 4 beers and 2 shrimp dinner orders. The second receipt for the same day at 5:15 PM was $30.00 for 1 beer and 2 orders of shrimp. Each transaction shows the credit card numbers were keyed in by the restaurant employee, and the order was under the name of V3. The facility's 6/9/26 final incident report documents the allegation of misappropriation of resident property was substantiated. V3 admitted to utilizing the residents credit card to make purchases for personal use in addition to purchases made for the resident.The facility November 2025 policy for Abuse, prevention and prohibition states that each resident has the right to be free from abuse. The facility prohibits mistreatment, neglect, or abuse of residents. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. The facility also prohibits misappropriation of resident property. Misappropriation of Resident Property is defined as the deliberate misplacement, exploitation, or (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.Prior to the survey date of 6/11/26, the facility had taken the following action to correct the noncompliance:1. On 6/4/26 the all-facility staff were in-serviced on abuse and the facility Abuse, Prevention and Prohibition Policy- with a specific focus on Misappropriation of Funds (including misappropriation of resident funds). Reviewed the policy regarding accepting monetary gifts from residents and/or resident representatives and the policy regarding assisting residents from procuring items.2. On 6/8/26 the Administrator was in-serviced by the Regional Nurse regarding abuse and neglect and ethics.3. On 6/4/26 Interviews were conducted with other resident to determine if they had any items/monies missing. The results of the interviews revealed that no residents were missing money.4. V3's employment was suspended on 6/4/26 and terminated on 6/10/26. 5. The QAA committee reviewed the incident to ensure that all corrective measures will be implemented.