

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER Crystal Pines Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>34117</p> <p>Based on observation, interview and record review the facility failed to ensure the prescribed treatment was applied to a resident with Moisture Associated Skin Damage. This applies to 1 of 18 residents (R13) reviewed for quality of care in the sample of 18.</p> <p>Findings include:</p> <p>R13's Physician Order Summary (P.O.S.) dated June 2024 shows orders wound care: left and right gluteal: cleanse with wound cleanser, gently pat dry. Apply collagen to wound bed, cover with large calcium sheet to cover wound areas not covering anus.</p> <p>R13's Wound Evaluation Non-Pressure Evaluation Report dated 5/27/24 documents right buttock wound Moisture Associated Skin Damage (MASD), bloody drainage, measuring 6.3 cm (centimeters) x 7.6 cm x 0.1 cm. Description of peri wound bed: macerated, reddened and denuded.</p> <p>R13's Wound Evaluation Non-Pressure Evaluation Report dated 5/27/24 documents left buttock wound MASD, bloody drainage, measuring 5.9 cm x 6.2cm x 0.1 cm. Description of peri wound: macerated, reddened and denuded.</p> <p>On 6/3/24 at 10:41 AM, V5 and V6 (Both Certified Nursing Assistant's-CNA's) provided incontinence care to R13. R13's bottom was red and excoriated. The top of his buttock fold was red and bleeding. Two large dressings were in place to both buttocks. R13 said it hurts my bottom, V5 replied, sorry it's raw and bleeding. At 11:03 AM, V4 (Wound Nurse) came into the room to provide wound care. V4 removed the old dressings, his bottom was excoriated with bleeding, several clusters of open areas were reddened on both side of his buttocks. V4 applied cream and did not apply a dressing. V4 said he applied remedy cream to R13's wound and did not have the calcium alginate dressing.</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 145257	Facility ID: 145257 If continuation sheet Page 1 of 16

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>35119</p> <p>Based on observation, interview, and record review the facility failed to ensure pressure relieving interventions were in place for a resident with a history of pressure injuries for 1 of 4 residents (R75) reviewed for pressure in the sample of 18.</p> <p>Findings include:</p> <p>On 06/03/24 at 09:52 AM, R75 was in bed on his back with his heels flat on the bed. R75's feet were up against the foot board with a pillow in between his feet and the foot board.</p> <p>On 6/4/24 at 12:50 PM, R75 was in bed on his back with his heels flat on the mattress. There were no heel boots observed.</p> <p>On 06/04/24 at 12:52 PM, V4 Wound Licensed Practical Nurse said R75 was admitted with a pressure injury to the arch of his foot and one on his heel that have since been resolved. V4 said the interventions for R75 are to float heel/feet of the bed with off loading boots when in bed. V4 said R75 sometimes doesn't like the boots due to being too hot, so then pillows should be used to keep heels off the bed. The pillows should keep the heels off the bed, so the heels aren't touching the mattress. Heels should not be up against foot board even if pillow in between, because it still is creating pressure.</p> <p>R75's Care Plan dated 4/3/24 shows R75 has actual skin impairment to skin integrity. Float heels while in bed as tolerated. Heel protectors on when in bed.</p> <p>The facility's Pressure Ulcer/Pressure Injury Prevention Policy dated 3/2022 shows A pressure ulcer/injury can occur wherever pressure has impaired circulation to the tissue a facility must: implement, monitor and modify interventions to attempt to stabilize, reduce or remove underlying risk factors.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35119</p> <p>Based on observation, interview, and record review the facility failed to assess and implement interventions for a resident with contractures for 1 of 7 residents (R75) reviewed for range of motion in the sample of 18.</p> <p>Findings include:</p> <p>On 06/03/24 at 9:51 AM, R75 was in bed with his left arm and hand flat on the bed. R75's left arm/hand was slightly edematous. R75's fingers on his left hand were curled under towards the palms of his hand. R75 shook his head no when asked if he could move his left hand.</p> <p>On 6/4/24 at 10:29 AM, V12 Restorative Certified Nursing Assistant said she was not doing restorative therapy for R75's contracture.</p> <p>On 6/4/24 at 11:00 AM, V13 Regional Registered Nurse said there is no restorative program for R75. R75 has a contraction to his left fingers at the first joint. V13 said she just went and looked at R75's left hand and saw some swelling so she elevated the hand and put rag between his fingers and his palm. V13 said R75 had therapy when he first admitted , but is not on physical therapy now. V13 said she will look for the initial admission assessment of R75's left hand contracture.</p> <p>R75's most recent Care Plan shows R75 was admitted on [DATE] with diagnoses of spastic hemiplegia affecting left side and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. This same care plan does not show R75 has a contracture to the left hand or interventions for the contracture.</p> <p>On 6/04/24 at 1:00 PM, V13 said there was no assessment of R75's left hand contracture done on admission. V13 said Occupational Therapy didn't see R75 so there is no evaluation on his left hand contracture. There is no restorative recommendations due to not being seen by occupational therapy. V13 said there should be interventions in place in order to prevent the contracture from getting worse.</p> <p>The facility's undated Restorative Nursing Policy and Procedure shows It is the policy of this facility to provide restorative nursing, which promotes the resident's ability to adapt and adjust to living as independently and safely as possible. Restorative nursing focuses on achieving and/or maintaining optimal physical, mental, and psychological function of the resident.</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34117</p> <p>Based on observation, interview and record review the facility failed to ensure a resident who is a high risk for falls was supervised and ensure fall interventions were in place. This failure resulted in R6 falling forward out of her wheelchair and hitting her head on the floor. R6 sustained a forehead laceration requiring transport to the hospital and R6 requiring sutures. This applies to 1 of 18 residents (R6) reviewed for safety in the sample of 18.</p> <p>Findings include:</p> <p>R6's face sheet shows R6's diagnoses including unspecified dementia, unspecified psychosis, anxiety, delusional disorders, repeated falls, peripheral vascular disease and hallucinations.</p> <p>R6's Fall Risk assessment dated [DATE] shows she is a HIGH risk for falls.</p> <p>R6's careplan revised on 6/3/24 shows she is a risk for falls, due to weakness, balance problems, dementia, urinary bladder incontinence, psychotropic/opiate medication use and has a history of falls. Interventions include anti-tippers on front of wheelchair's, anti-slip mat under wheelchair cushion, ensure appropriate footwear, low bed, provide reacher/grabber. This careplan shows she has severe impaired mental function with interventions including to engage R6, in simple, structured activities, provide a program of activities, she requires supervision and assistance when interacting with other residents.</p> <p>The facility's Incident Report dated 5/28/24 documents R6 was found lying on her right side, left side of head facing upward on the floor on the (specific floor) television (TV) room. According to another resident (R21) sitting in the room she (R6) fell forward while reaching for something. (R6) had been wheeling herself around the halls post dinner, the CNA was going in and out of other resident rooms . R1 was transferred to the local hospital and returned with sutures to her forehead.</p> <p>On 6/3/24 at 10:26 AM, R6 was observed self-propelling in her wheelchair going up and down the halls. R6 had a dark purple bruise under her left eye, abrasion to the bridge of her nose and sutures to her left forehead. R6 asked this surveyor, can I go this way?</p> <p>6/4/24 at 8:32 AM, R6 was lying in her bed. A large purple bruise was observed on her left hand, dark purple bruise under left eye and light yellowish bruising to her right forehead. At 10:24 AM, R6's wheelchair was outside of her room with her name. R6's wheelchair had a cushion and did not have an (anti-slip mat) in place.</p> <p>On 6/4/24 at 8:36 AM, R21 said on 5/28/24 he was in the TV room with R6. R6 leaned forward from her wheelchair and hit her head on the floor. He called for help and the staff came.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/4/24 at 10:24 AM, V7 (Certified Nursing Assistant) said R6 is alert to self, she yells out, wanders into other resident rooms and takes things out of other resident rooms we try to re-direct her but she does not comprehend and she tries to get up without assistance. We have to keep a close watch on her. On 5/28/24, another family member reported R6 was wandering into her mother's room trying to take her mom's stuff. V7 said she was in another resident's room and heard someone yell for help. R6 was in the TV room on the floor with her wheelchair tipped over. R21 was in the room with R6 when it happened he said she was bending down reaching for something.</p> <p>On 6/5/24 at 4:20 PM, V8 (CNA) said on 5/28/24 she was R6's CNA. That day R6 was more confused, she was talking to the walls, she was strolling her in the wheelchair and spent a lot of time with her. V8 said R6 was bending forward out of her wheelchair several times prior to her fall that day, but did not know why. She placed R6 in front the nurses station and left to assist another resident. Later she heard someone yell out for help. R6 was on the floor bleeding with the wheelchair flipped over in the TV room on the 200 hall. R21 was in the room with her and called out for help. She said R6's wheelchair had only a cushion. When asked if R6 had an anti-slip mat, V8 replied What's that? She only had a cushion, R6 had dementia, is impulsive and needs to be supervised.</p> <p>On 6/5/24 at 9:04 AM, V2 (DON) said she's been at the facility for about two months. On 5/28/24 she was notified of R6's fall. On 5/28/24, R6 was in the dining room/TV room on the (specific location in facility) with R21. R21 said R6 was reaching down to pick something up and fiddling with her shoe. R6 fell forward and hit her head on the floor. She was bleeding and was sent out to the local hospital and received sutures to her forehead. R6's wheelchair should have anti-tippers and an anti-slip mat on top of her cushion to prevent her from falling out of her wheelchair. In the evening after dinner we try to keep her occupied because she has some sundowning. R6 has dementia and we are looking for placement to get her into a memory care unit. At 10:35 AM, V2 confirmed R6's wheelchair did not have an anti-slip mat to her wheelchair cushion. The anti-slip mats were locked up in the storage room.</p> <p>The facility's Falls Policy revised 9/2019, states, The purpose of the Fall Management Program is to develop, implement, monitor and evaluate an interdisciplinary team falls prevention approach and manage strategies and interventions that foster resident independence and quality of life .residents found to be at high risk for falls are placed on the Fall Program, and Interventions are implemented to meet individual needs .</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>35119</p> <p>Based on observation, interview, and record review the facility failed to ensure a urinary catheter urine collection bag was positioned off the floor to prevent cross-contamination for 1 of 10 residents (R24) reviewed for urinary catheters in the sample of 18.</p> <p>Findings include:</p> <p>On 6/3/24 at 9:25 AM, R24's urinary catheter bag was full with urine and was resting on the floor under R24's bed.</p> <p>On 6/3/24 at 12:28 PM, R24's urinary catheter bag (still full of urine) was resting on floor. R24 stated they just came in here and put the catheter bag in a privacy bag.</p> <p>On 6/4/24 9:35 AM, R24's urinary catheter bag was resting on floor.</p> <p>On 6/4/24 at 12:52 PM, V11 Licensed Practical Nurse said urinary catheter bags should be placed below the level of the bladder and not on floor. V11 said the urinary catheter bag should not be touching a contaminated surface (the floor) for infection control.</p> <p>R24's Physician Order shows (Urinary) catheter 18 french 30 ml (milliliter) balloon for obstructive and reflux uropathy.</p> <p>The facility's Catheter Care Policy dated January 2017 shows be sure the catheter tubing and drainage bag are kept off the floor.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>35119</p> <p>Based on observation, interview, and record review the facility failed to ensure R75's enteral nutrition bag was labeled for 1 of 4 residents (R75) reviewed for enteral feedings in the sample of 18.</p> <p>Findings include:</p> <p>On 6/3/24 at 9:49 AM, R75's feeding pump was running at 70 ml (milliliters)/hr (hour). The enteral feeding bag was labeled with R75's name and a date of 5/31/24. The enteral feeding bag did not contain the name of the contents of the bag or when the feeding was started.</p> <p>R75's Physician Orders dated June 2024 shows Administer Isosource 1.5 via G-tube at 70 cc (cubic centimeters)/hr. On at 1300 (1:00 PM) off at 0900 (9:00 AM). Total volume to be infused 1400 ml in 24 hours. May turn off for short periods of time for care and services. Verify total volume infused prior to turning off.</p> <p>On 6/4/24 at 1:05 PM, V15 Nursing Supervisor said R75 gets Iso-source 1.5 from 1:00 PM to 9:00 AM. V4 stated We pour Iso-source cans into feeding tube bag and then we label the bag with residents name, date of birth, order- Iso Source 1.5, total to infuse, and date and time hung. If the bag is not labeled, you wouldn't be able to know what it was and verify it with the order in computer.</p> <p>The facility's Enteral Tube Feeding via Gravity Bag dated 1/2022 shows 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, and rate of administration. On the formula label document initials, and date and time the formula was hung.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>35119</p> <p>Based on observation, interview, and record review the facility failed to ensure residents oxygen equipment was changed and labeled for 4 of 9 residents (R4, R14, R24, R34) reviewed for oxygen use in the sample of 18.</p> <p>Findings include:</p> <p>1. On 6/3/24 at 9:59 AM, R4's oxygen tubing and humidification water bottle, connected to the oxygen concentrator were not dated.</p> <p>On 6/3/24 at 10:16 AM, R4 was up in her wheelchair with a portable oxygen tank. R14 was wearing a nasal canula tubing which was undated.</p> <p>R4's June Physician orders shows Oxygen Tubing - Change Weekly every night shift every Sunday for infection control and Oxygen at 2 L/min via nasal canula, PRN. Maintain saturation >90% as needed for Anxiety and congestive heart failure.</p> <p>On 6/4/24 at 12:52 PM, V11 Licensed Practical Nurse said oxygen tubing is changed every Sunday on night shift, both the tubing and the bubbler, for infection control. V11 said the tubing and bubbler should be labeled and dated to show when they were changed.</p> <p>2. On 6/3/24 at 9:19 AM, R14 was in bed with a nasal canula on. R14's oxygen tubing was not dated and R14's humidification water bottle was dated 5/17/24.</p> <p>R14's June Physician Orders does not contain any orders to change oxygen tubing/water bottle.</p> <p>3. On 6/3/24 at 9:28 AM, R24 was in bed, with oxygen on via nasal canula. R24's tubing was not dated.</p> <p>R24's Physician Orders dated 5/4/24 shows Oxygen Tubing - Change Weekly every night shift every Sun.</p> <p>4. On 6/3/24 at 10:20 AM, R34 was in bed with oxygen on via nasal canula. R34's oxygen tubing was not dated.</p> <p>R34's Physician Orders dated 5/19/24 shows Oxygen Tubing - Change Weekly every night shift every Sun.</p> <p>The facility's Oxygen Administration Policy dated January 2017 does not address oxygen tubing or humidification water bottle changes.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45540</p> <p>Based on interview and record review the facility to administer medications at the prescribed time. This applies to 4 of 18 residents (R47, R70, R28, R30) in sample of 18 reviewed for medication administration.</p> <p>The findings include:</p> <p>1. On 6/3/2024 at 10:52AM, R47 said there was a nurse call in on Saturday (6/1/2024) and her medications were given late. R47 said her morning medications are normally given around 9:00AM, but on Saturday were given between 2:00PM - 2:30PM. R47 is alert and oriented.</p> <p>On 6/5/2024 at 9:52AM, V9 Staffing Coordinator said there was a nurse call in on Saturday 6/1/2024 for the morning shift.</p> <p>On 6/4/2024 at 1:20PM, V2 Director of Nursing (DON) said medications should be given one hour before or after the scheduled time.</p> <p>R47's Medication Administration (Admin) Audit Report dated 6/1/2024 shows an order for Metoprolol Tartrate Oral Tablet (Antihypertensive) 25 milligrams (mg) give 1 tablet by mouth two times a day. Scheduled date/time was 6/1/2024 at 9:00AM, administered date/time was 6/1/2024 at 2:31PM.</p> <p>R47's Medication Admin Audit Report dated 6/1/2024 shows an order for Gabapentin (Anticonvulsant) Oral Capsule 100mg give 2 capsules by mouth three times a day. Scheduled date/time was 6/1/2024 at 9:00AM, administered date/time was 6/1/2/2024 at 2:31PM.</p> <p>R47's Medication Admin Audit Report dated 6/1/2024 shows an order for DULoxetine HCL (Hydrochloride) (Antidepressant) Oral Capsule Delayed Release Particles 20mg give 1 capsule by mouth two times a day. Scheduled date/time was 6/1/2024 at 9:00AM, administered date/time was 6/1/2024 at 2:31PM.</p> <p>R47's Medication Admin Audit Report dated 6/1/2024 shows an order for Bumetanide (Diuretic) Tablet 1mg give 1 tablet by mouth two times a day. Scheduled date/time was 6/1/2024 at 9:00AM, administered date/time was 6/1/2024 at 2:31PM.</p> <p>The facilities Medication Pass Tips policy dated May 2019, states . Administer each medication as instructed on the eMAR and within the time-frame established by the facility. The medication pass should be completed within the 2 hour time frame: 1 hour before or 1 hour after the ordered time.</p> <p>34506</p> <p>2. R70's Admission Record dated June 5, 2024 shows he was admitted to the facility on [DATE] with diagnoses including duodenal ulcer, congestive heart failure, chronic kidney disease, alcoholic cirrhosis of liver, nausea with vomiting, alcohol abuse, major depressive disorder, anxiety disorder, gastro-esophageal reflux disease, and acute respiratory failure with hypoxia.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On June 4, 2024 at 10:15 AM, during resident council meeting, R70 said last Saturday (June 1, 2024) he did not receive his morning medications until about 1:00 PM. R70 said it was a nurse from an agency. R70 said he takes depression medications, anxiety medications, and medicine to keep his ammonia levels down. R70 said if he does not get the medication to keep his ammonia levels down, then he passes out. R70 said he was frustrated and worried about not getting his medications on time since he has passed out before.</p> <p>R70's Medication Administration Report shows that on June 1, 2024 R28 received his 8:00 AM and 9:00 AM medications at 1:11 PM and 1:12 PM. This same report shows that R70 should receive pantoprazole (Anti-reflux daily related to gastro-esophageal reflux disease at 8:00 AM, rifaximin (Antibiotic) two times daily for metabolic encephalopathy at 9:00 AM and 5:00 PM, lactulose (osmotic laxative) two times a day related to alcoholic cirrhosis of liver-titrate for bowel movement 3-4 times per day at 9:00 AM and 5:00 PM, and coreg (beta-blocker heart medication) two times a day for high blood pressure at 9:00 AM and 5:00 PM.</p> <p>On June 5, 2024 at 11:18 AM, V1 Administrator said she wasn't aware that medications were given late on Saturday (June 1, 2024) until she came in on the following Monday and saw a grievance form in her box from a resident that said his medications were given late. V1 said the nurse that gave the medications late will no longer be returning to the facility.</p> <p>3. R28's Admission Record dated June 5, 2024 shows she was admitted to the facility on [DATE] with diagnoses including osteoarthritis, major depressive disorder, personal history of traumatic fracture, anxiety disorder, high blood pressure, convulsions, and cerebral infarction.</p> <p>On June 4, 2024 at 10:15 AM, during resident council meeting, R28 said she received her morning medications late last Saturday (June 1, 2024).</p> <p>R28's Medication Admin Audit Report dated June 4, 2024 shows she receives tizanidine three times per day for muscle relaxer at 9:00 AM, 1:00 PM, and 8:00 PM. On June 1, 2024, R28 received this medication at 11:56 AM, 2:52 PM, and 8:37 PM. R28 should receive dilantin every morning and at bedtime for convulsions at 9:00 AM and 9:00 PM. R28 received her morning dose at 11:56 AM. R28 should receive keppra two times daily related to convulsions at 9:00 AM and 5:00 PM. R28 received her keppra at 11:56 AM.</p> <p>4. R30's Admission Record dated June 5, 2024 shows he was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, major depressive disorder, hearing loss, osteoarthritis, and psychotic disorder with hallucinations.</p> <p>On June 4, 2024 at 10:15 AM, during resident council meeting, R30 nodded his head yes when he was asked if he received his medications late on the past Saturday. R30 is non verbal.</p> <p>R30's Medication Administration Record dated June 1, 2024-June 30, 2024 shows R30 receives Rytary (Antiparkinsons) extended release (carbidopa-levodopa extended release) three capsules at 7:00 AM, two capsules at 10:30 AM, 2:00 PM, and 5:30 PM, and one capsule at 9:00 PM.</p> <p>R30's Medication Admin Audit Report dated June 4, 2024 shows he received rytary two capsules at 12:30 PM (scheduled at 10:30 AM), 3:10 PM (scheduled at 2:00 PM), and 4:37 PM (scheduled at 5:30 PM).</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Crystal Pines Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's Administration of Medications policy revised on April 2021 shows, Immediately after a drug is ingested, it should be recorded on the MAR (Medication Administration Record). The facility shall check the Physician's Order sheet and MAR against the current physician's orders to assure proper administration of medications to each resident.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506</p> <p>Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for three of 18 residents (R70, R28, R30) reviewed for medications in the sample of 18.</p> <p>Findings include:</p> <p>1. R70's Admission Record dated June 5, 2024 shows he was admitted to the facility on [DATE] with diagnoses including duodenal ulcer, congestive heart failure, chronic kidney disease, alcoholic cirrhosis of liver, nausea with vomiting, alcohol abuse, major depressive disorder, anxiety disorder, gastro-esophageal reflux disease, and acute respiratory failure with hypoxia.</p> <p>On June 4, 2024 at 10:15 AM, during resident council meeting, R70 said last Saturday (June 1, 2024) he did not receive his morning medications until about 1:00 PM. R70 said it was a nurse from an agency. R70 said he takes depression medications, anxiety medications, and medicine to keep his ammonia levels down. R70 said if he does not get the medication to keep his ammonia levels down, then he passes out. R70 said he was frustrated and worried about not getting his medications on time since he has passed out before.</p> <p>R70's Medication Administration Report shows that on June 1, 2024 R28 received his 8:00 AM and 9:00 AM medications at 1:11 PM and 1:12 PM. This same report shows that R70 should receive rifaximin (antibiotic) two times daily for metabolic encephalopathy at 9:00 AM and 5:00 PM, lactulose (osmotic laxative) two times a day related to alcoholic cirrhosis of liver-titrate for bowel movement 3-4 times per day at 9:00 AM and 5:00 PM, and coreg two times a day for high blood pressure at 9:00 AM and 5:00 PM.</p> <p>2. R28's Admission Record dated June 5, 2024 shows she was admitted to the facility on [DATE] with diagnoses including osteoarthritis, major depressive disorder, personal history of traumatic fracture, anxiety disorder, high blood pressure, convulsions, and cerebral infarction.</p> <p>On June 4, 2024 at 10:15 AM, during resident council meeting, R28 said she received her morning medications late last Saturday (June 1, 2024).</p> <p>R28's Medication Admin Audit Report dated June 4, 2024 shows she receives dilantin every morning and at bedtime for convulsions at 9:00 AM and 9:00 PM. R28 received her morning dose at 11:56 AM. R28 should receive keppra two times daily related to convulsions at 9:00 AM and 5:00 PM. R28 received her keppra at 11:56 AM.</p> <p>3. R30's Admission Record dated June 5, 2024 shows he was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, major depressive disorder, hearing loss, osteoarthritis, and psychotic disorder with hallucinations.</p> <p>On June 4, 2024 at 10:15 AM, during resident council meeting, R30 nodded his head yes when he was asked if he received his medications late on the past Saturday. R30 is non verbal.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R30's Medication Administration Record dated June 1, 2024-June 30, 2024 shows R30 receives Rytary (Antiparkinson) extended release (carbidopa-levodopa extended release) three capsules at 7:00 AM, two capsules at 10:30 AM, 2:00 PM, and 5:30 PM, and one capsule at 9:00 PM.</p> <p>R30's Medication Admin Audit Report dated June 4, 2024 shows he received rytary two capsules at 12:30 PM (scheduled at 10:30 AM), 3:10 PM (scheduled at 2:00 PM), and 4:37 PM (scheduled at 5:30 PM).</p> <p>On June 5, 2024 at 11:18 AM, V1 Administrator said she wasn't aware that medications were given late on Saturday (June 1, 2024) until she came in on the following Monday and saw a grievance form in her box from a resident that said his medications were given late. V1 said the nurse that gave the medications late will no longer be returning to the facility.</p> <p>The facility's Administration of Medications policy revised on April 2021 shows, Immediately after a drug is ingested, it should be recorded on the MAR (Medication Administration Record). The facility shall check the Physician's Order sheet and MAR against the current physician's orders to assure proper administration of medications to each resident.</p> <p>On June 5, 2024 at 12:30 PM, V2 DON (Director of Nursing) said the facility does not have a policy in regards to significant medication errors.</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506</p> <p>Based on observation, interview, and record review, the facility failed to prepare and serve food to meet residents' needs for four of 18 residents (R28, R29, R3, R8) reviewed for food in the sample of 18.</p> <p>1. R28's Admission Record dated June 5, 2024 shows she was admitted to the facility on [DATE] with diagnoses including cerebral infarction due to embolism of unspecified cerebral artery.</p> <p>R28's Order Summary Report dated June 5, 2024 shows an order for regular texture diet, no cranberry juice, and no green leafy vegetables. R28's order summary report shows that R28 is on coumadin (blood thinner).</p> <p>On June 4, 2024 at 10:15 AM, during resident council meeting, R28 said that she is not supposed to eat green leafy vegetables because she is on coumadin. R28 said the green leafy vegetables thickens her blood. R28 said she gets green leafy vegetables frequently. R28 said she got spinach on her lunch tray on June 3, 2024. R28 said she did not receive any other vegetable as an alternative to the spinach.</p> <p>The facilities Diet Guide sheet shows that sauteed spinach with garlic was served for the lunch meal.</p> <p>On June 3, 2024 the facility served spinach and broccoli as vegetable options for the lunch meal. There were no other vegetable options served off of the steam table.</p> <p>On June 5, 2024 at 11:37 AM, V21 District Manager/Certified Dietary Manager said residents on coumadin should receive carrots as an alternate for the vegetable option. V21 said he did know why R28 received spinach.</p> <p>R28's Activity Log Report dated May 22, 2024 shows, NO SPINACH, NO LEAFY GREENS, NO GRAVY.</p> <p>2. The facility's Diet Type Report dated June 5, 2024 shows that R29, R3, and R8 receive puree diets.</p> <p>On June 4, 2024 at 12:45 PM, a test tray was sampled. The barbeque hamburger was not a smooth consistency, free of small chunks, and required some chewing. At 1:00 PM, V21 sampled the same pureed barbeque hamburger and said the puree had little bumps and was a little gritty. V21 said the meat should be a smooth consistency.</p> <p>The facility's Menus policy revised September 2017 shows, Menus will be planned in advance to meet the nutritional needs of the residents/patients in accordance with established national guideline.</p> <p>The facility's Food: Quality and Palatability policy revised February 2023 shows, Food and liquids are prepared and served in a manner, form, and texture to meet resident's needs.</p> <p>(continued on next page)</p>

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's Pureed Diet and Nutrition Care Manual dated 2021 shows, All foods must be the consistency of moist mashed potatoes or pudding.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34117</p> <p>Based on observation, interview and record review the facility failed to ensure staff donned all applicable Personal Protective Equipment while providing direct care to a resident with Enhanced Barrier Precautions. This applies to 1 of 18 residents (R13) reviewed for infection control in the sample of 18.</p> <p>The findings include:</p> <p>R13's Physician Order sheets dated June 2024 shows R13's diagnoses including obstructive and reflux uropathy, benign prostatic hyperplasia with lower urinary tract symptoms, peripheral vascular disease and complete traumatic amputation at level between knee and ankle left and right lower leg. R13's Physician's Order Sheet (POS) shows orders for enhanced barrier precautions related to urinary catheter and wound care every shift wear gloves and gown when providing high contact care.</p> <p>On 6/3/24 at 10:41 AM a sign was posted outside of R13's door. Enhanced Barrier Precautions. V5 and V6 (Both Certified Nursing Assistant's-CNA) donned gloves and did not wear a gown, they transferred R13 from his wheelchair to his bed, emptied R13's urinary catheter and provided incontinence care to R13. R13's bottom had several open wounds.</p> <p>On 6/4/24 at 10:24 AM, V7 (CNA) said staff should wear gown and gloves when providing direct care to residents who are on enhanced barrier precautions.</p> <p>The facility's Infection Prevention and Control [NAME] Enhanced Barrier Precautions undated Policy states, Enhanced Barrier Precautions are infection control intervention designed to reduce transmission of multidrug-resistant (MDROs) in nursing home .Enhanced Barrier Precautions are recommended for residents with any of the following .a wound or indwelling medical device, even if the resident is not known to be infected or colonized with a MDRO. Indwelling medical devices include central venous catheters, urinary catheters, feeding tubes .high contact resident care activities where a gown and gloves should be used include: transferring residents from one position to another, changing briefs or assisting with toileting, caring for or using an indwelling medical device, performing wound care.</p>		