PRINTED: 07/21/2024 FORM APPROVED

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDILAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:			LLILD	
		IL6002299	B. WING		05/0	8/2024	
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
CRYSTA	L PINES REHAB & HO	CC	H ILLINOIS				
		CRYSTAL	LAKE, IL 6	0014			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CORRECTION (CROSS-REFERENCE)	D BE	(X5) COMPLETE DATE	
S 000	Initial Comments		S 000				
	Investigation of Fac 4/27/24/IL172859	cility Reported Incident of					
S9999	Statement of Licensure Violations		S9999				
	300.690b)c)						
	Section 300.690 In	cidents and Accidents					
	any serious inciden this Section, "seriou	shall notify the Department of t or accident. For purposes of us" means any incident or es physical harm or injury to a					
	the Regional Office reportable incident incident or accident resident, the facility law enforcement punotify the Regional purposes of this Se Office by phone on Department represephone that the requiponable to contact the notify the Department hotline. The facility summary of each reto the Department voccurrence.	shall, by fax or phone, notify within 24 hours after each or accident. If a reportable tresults in the death of a shall, after contacting local ursuant to Section 300.695, Office by phone only. For the ection, "notify the Regional ly" means talk with a entative who confirms over the uirement to notify the Regional is been met. If the facility is ne Regional Office, it shall ent's toll-free complaint registry shall send a narrative eportable accident or incident within seven days after the					
	These requirement	s were not met as evidenced					

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 05/22/24

TITLE

Illinois Department of Public Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6002299	B. WING 05/08/2024			
	PROVIDER OR SUPPLIER L PINES REHAB & HO	CC 335 NORT	DRESS, CITY, S TH ILLINOIS LAKE, IL 60			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S9999	Continued From pa	ge 1	S9999			
	failed to report a res	and record review, the facility sident injury for 1 of 3 wed for accidents in the				
	The findings include	e:				
	he was having an x him on a hard plate onto the place a littl position where he h his lower back. R1: and the Certified No	M, R1 said about a month ago ray. R1 said the tech placed for the x-ray and rolled him to too hard. R1 said he hit in a leard a crack and had pain in said he told the x-ray tech, V6 ursing Assistant (CNA), V4 rack and felt the pain in his				
	week" after V6 did I he could sue becau doing his x-ray. V4 R1's back injury after	AM, V4 said about "a half a R1's x-ray, R1 told V4 maybe use V6 injured R1's back while said she told a nurse about er her conversation with R1, when the converse told.				
	report from the Emo when R1 was sent and was told R1 ha fracture which woul intervention. V3 sai fracture to the next	AM, V3 said she received ergency Room (ER) nurse back to the facility (on 4/27/24) d an unspecified sacral d resolve by itself with no d she reported R1's sacral shift nurse, but did not report the Director of Nursing				
	gone to the ER on and returned later. After Visit Summary	AM, V2, DON said R1 had 4/27/24 due to abdominal pain V2 said when she read R1's y (AVS) from the hospital (on hat R1 had a sacral fracture.				

Illinois Department of Public Health

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPI	E CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
			2.220.			,
		IL6002299	B. WING		1	8/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CDVSTAI	L PINES REHAB & HO	335 NORT	H ILLINOIS	AVENUE		
CRISIA	L PINES REHAD & HC	CRYSTAL	LAKE, IL 6	0014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From page 2		S9999			
	V2 said no one reported R1's sacral fracture to her.					
	On 5/8/24 at 12:13 PM, V1, Administrator/Abuse Coordinator, said the first she heard about R1 having a sacral fracture was after V2 spoke to R1 about his injury. V1 said based on what R1 told V2 about his injury, she believed they found the cause of R1's sacral fracture. V1 said she thought it was very clear what happened based on what R1 reported because he is alert and oriented and very credible. V1 said staff are supposed to be reporting a resident injury immediately to her, the DON, or the nurse on call. V1 said injuries should be addressed immediately around the clock within hours of an injury or allegation. V1 said the nurse should have informed her or V2 about R1's sacral fracture findings before V2 discovered it on R1's AVS.					
	an order for an abd R1's abdominal x-ra was the tech who p x-ray on 4/15/24. R without Contrast res nondisplaced distal	ry Report dated 5/8/24 shows ominal x-ray dated 4/13/24. ay Patient Report shows V6 erformed R1's abdominal 1's CT Abdomen Pelvis sults dated 4/27/24 show a sacral fracture. R1's CT sults from 10/12/23 do not ure.				
	PM shows V3 was	Note effective 4/27/24 at 2:45 told R1 has a nondisplaced ne ER charge nurse.				
	R1's Minimum Data is cognitively intact.	Set dated 2/23/24 shows R1				
	The facility's State I fracture is dated 4/3	Report regarding R1's sacral 30/24.				

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
						С	
		IL6002299	B. WING		05/0	08/2024	
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 335 NORTH ILLINOIS AVENUE CRYSTAL PINES REHAB & HCC CRYSTAL LAKE, IL 60014						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
\$9999	Continued From pa	ge 3 (C)	S9999				

Illinois Department of Public Health

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