STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002299	A. BUILDING: _____ B. WING _____	C 01/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL PINES REHAB & HCC	335 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014

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S000	Initial Comments Complaint Investigation: 2310220/IL155161	S 000		
S9999	Final Observations Statement of Licensure Violations I of II: 300.610a) 300.1210a) 300.1210b) 300.1210d)3)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	S9999		

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S9999	Continued From page 2	S9999		

review the facility failed to implement fall precaution interventions to prevent falls for 2 of 3 residents (R1, R3) reviewed for falls in the sample of 4. This failure resulted in R3 experiencing 5 falls between 11/26/22 and 1/11/23 requiring R3 to be transferred to the acute care hospital for evaluation each time.

The findings include:

1. R3's face sheet showed he was admitted to the facility on 7/19/22 with diagnoses to include aphasia, anemia, major depressive disorder, anxiety disorder, hydrocephalus, gastrointestinal hemorrhage, and cutaneous abscess of abdominal wall. R3's facility assessment dated 10/25/22 showed he has short term memory problems, severely impaired decision-making processes, and requires extensive assist with activities of daily living.

The facility's fall log for the previous 3 months showed R3 had fallen on 11/28/22 and 1/11/23. R3's medical record showed he had also experienced falls on 11/26/22, 11/29/22, and 12/12/22. R3's records showed he fell from his wheelchair on 11/26/22, 11/28/22, 12/12/22, and 1/11/23.

R3's nursing note dated 11/26/22 at 11:39 AM showed, "Resident received crying and inconsolable. Night nurse administered valium at 6:39 AM. He is sad and wants to speak with family members.. attempted to call all the numbers listed by the resident's wall... Asked the CNA to get up the resident for mealtime and so his mood will brighten up. Will give Valium when it is due at 2:39 PM..."

R3's nursing note dated 11/26/22 at 5:04 PM

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S9999	Continued From page 3 showed, "... Writer went to the nurse station to report the incident to [R3's Physician or Nurse Practitioner]... as soon as writer sat, CNA called me and said resident was unresponsive, went immediately to patient's room and saw another CNA doing chest rub, resident with pulse and breathing. I immediately called 911 and emergency cart brought to the resident's room Resident was in and out of consciousness.... unable to do blood pressure due to resident's movement..." R3's SBAR Communication Form dated 11/26/22 at 3:30 PM showed, "At around 2:40 PM, writer was in break room when another nurse came and told me the resident was on the floor. Went immediately to the patient's room and observed him laying on the floor by the bed. He was crying. He's been sad the entire shift. Asked if he hit his head on the floor, he was just saying "ok" and crying... fall is unwitnessed. Resident was assisted back to the wheelchair..." R3's nursing note dated 11/28/22 showed, "... The resident is experiencing a change in condition... Resident had an unwitnessed fall at 1:00 PM in the dining room. Noted resident on his right side on the floor in dining room, no bleeding or bruises noted. Resident was assisted back to his wheelchair and brought him in his room on the bed.... Resident was sad and crying this morning..." R3's care plan initiated 11/28/22 showed, "[R3] is at risk for falls related to deconditioning, gait/balance problems, foley catheter, psychoactive medication use, and traumatic brain injury...Intervention added on 12/1/22, adjust seat wheelchair for positioning aide for forward and side slumping.	S9999		

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S9999	Continued From page 4 R3's 11/28/22 fall risk data collection sheet showed R3 is a high risk for falls. R3's 1/11/23 fall risk data collection showed R3 had an unwitnessed fall in his room on 1/11/23. R3's acute care hospital documentation dated 11/30/22 showed, "Chief Complaint, Unwitnessed fall... History obtained from patient's daughter who states patient is unable to verbalize his symptoms at baseline. She reports three falls this week, first one occurred on Saturday where patient fell out of wheelchair, another fall from wheelchair on Sunday, and today had a fall from bed..." R3's acute care hospital "After Visit Summary" dated 12/12/22 showed, "... Reason for Visit, Fall, Diagnoses: Head injury, fall from wheelchair, history of traumatic brain injury... Instructions: ... Consider increasing supervision levels while in wheelchair due to frequent falls. Monitor patient closely while he is up sitting in wheelchair - especially while giving any sedative medications to help prevent future falls..." R3's nursing note dated 1/11/23 at 10:46 AM showed, "Resident very anxious, (anxiety pill) offered, this resident covered his mouth and got very angry and kept saying okay and no okay... Attempted to give medications again and he kept shaking his head and covered his mouth again. Placed medication down on the counter at the nurses station and this resident pushed the medication off the counter, resident angry also about foot pedals. This RN (Registered Nurse) attempted to change foot pedals and still angry." R3's nursing note dated 1/11/23 at 2:54 PM showed, "The resident is experiencing a change	S9999		

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S9999	Continued From page 5 in condition.. fell out of chair onto his right side and the right side of his head has a bump and he is hard to arouse... He has been anxious/agitated all day refusing to take his medications, refused to go to bed after breakfast and slept on the nurses station. Resident went to lunch in the main dining room and was returned to his room for a short while until he could be placed into bed. This resident fell on the floor unwitnessed and appears to have hit his head on the right side where his shunt is. resident was placed into bed and was arousable and crying at that time. Neuro checks started after he was placed into bed and became very lethargic and arousable by sternal rubs and loud noises. Eyes rolled into head when light was shined into his eyes, unable to follow commands at this time." R3's nursing note dated 1/11/23 at 10:00 PM showed, "Returned from [acute care hospital] in stable condition, daughter at bedside and very upset stating she wants him to have a fall risk bracelet and signs on his door and above his bed..." On 1/12/23 at 2:18 PM, V4 (Registered Nurse/RN) said R3 is impulsive and easily agitated. V4 said on 1/11/23 R3 refused to take his medications and pushed them off the counter onto the floor. V4 said on 1/11/23 R1 had been brought back to the unit from the dining room after lunch by the activity aide. V4 said she told the activity aide to put him in his room and they would be in to put him into bed soon. V4 said she felt it was ok to leave him in his room unsupervised because she was going to the bathroom, and he would have been unsupervised at the nursing station as well. V4 said when she came out of the bathroom R3 was noted to be on the floor. V4 said R3 had a lump on his head near	S9999		

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S9999	Continued From page 6 his shunt, is on blood thinners, and became lethargic after the fall so they sent him to the emergency room to be evaluated. On 1/12/23 at 4:30 PM, V2 (Director of Nursing/DON) said the reason R3's falls on 11/26/22, 11/29/22, and 12/12/22 were not on the fall log is because they were not entered in the facility's software which is used to track and investigate falls because the system had some kind of glitch. V2 said the other documentation in R3's record regarding those falls would be the investigation. V2 said R3 is and is not safe in his wheelchair unsupervised. V2 said R3 gets easily agitated and when he is agitated, he is unsafe to be left alone. 2. R1's medical record showed he was admitted to the facility on 11/11/22 with diagnoses to include disorders of electrolyte and fluid balance, muscle weakness, unsteadiness on feet, cognitive communication deficit, apraxia (neurological movement disorder), and dementia. R1's facility assessment dated 11/17/22 showed he has short and long term memory problems and requires extensive to total assist for all activities of daily living. On 1/11/23 at 1:54 PM, V12 (R1's Daughter) said R1 had a fall on 12/11/22 during which he sustained a broken nose and required 6 sutures. V12 said was not safe to be alone in his room in his wheelchair and he was left in there anyway. V12 said after R1's fall on 12/11/22 the facility got him a new wheelchair that was more reclined so he would not be able to fall out. V12 said she spoke with staff at the facility prior to R1's 12/11/22 fall and told them he is a high risk for falls and cannot be left alone.	S9999		

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S9999	Continued From page 7 R1's care plan initiated 11/16/22 showed, "[R1] is at risk for falls due to dementia, gait/balance problems, poor communication, apraxia, weakness, and deconditioning... Interventions, Assess clothing for proper fit, Assess for UTI..., Be sure [R1] call light is within reach and encourage the resident to use it for assistance as needed, Ensure personal items are within reach, Ensure that the resident is wearing appropriate non-skid footwear when ambulating or mobilizing wheelchair..." The same care plan showed updates added after he was readmitted from the acute care hospital to "Apply floor mats to both sides of resident's bed. Apply floor mats to both sides of resident's wheelchair, Dropped seat in wheelchair to facilitate appropriate positioning, Reclining back wheelchair for positioning aide for forward slumping, Resident to lay down after meals and therapy, per POA/family request/wishes. Resident will not be left in the wheelchair after meals and therapy." R1's acute care hospital documentation dated 12/13/22 showed, "Admit date: 12/11/22... Chief Complaint, Patient presents with unwitnessed fall from wheelchair at 3:30 this afternoon... laceration to forehead, abrasion and swelling to nose... Alert and oriented to 1 at baseline... Admission Diagnosis: Facial laceration...closed fracture of nasal bone... hematoma of scalp...Fall at nursing home... unwitnessed fall... HPI (History of Present Illness) Patient is an 86-year old man with past medical history relevant for hypertension, gout, depression, chronic atrial fibrillation not on anticoagulation, bedridden, severe dysarthria, resident of [nursing facility], currently presenting after being found on the floor.... History is taken from his daughter at bedside. The patient is unable to walk or get out of the bed on his own, but he sometimes is put in	S9999		

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S9999	Continued From page 8	S9999		

a wheelchair. Apparently, the patient was in wheelchair today but was then found on the floor having an unwitnessed fall with blood coming out of his head and swelling of the nose.... CT head negative for bleeding but showed nasal bone fracture. He was admitted for observation and possible change in SNF (skilled nursing facility)... Safety Awareness, decreased awareness of need for assistance, decreased awareness of need for safety and impulsive, not aware of deficits..."

On 1/13/23 at 9:22 AM, V11 (Certified Nursing Assistant/CNA) said she worked that day and responded to R1's fall. V11 said when she started her shift, she had seen R1 in his room in his wheelchair. V11 said she had gone down the hall to another resident's room and on the way back to the nurses station area she saw R1 in his room laying on the floor. V11 said she called the nurses for help, they called 911 and R1 was taken to the hospital. V11 said after R1 left she was talking to someone that comes in to see R1 and they told her he should not be in his wheelchair alone because he tries to get up. V11 said if she would have known about him trying to get up in the past, she would not have let him be left in his room.

On 1/12/23 at 11:30 AM, V2 (DON) said R1 had been taken to his room from the dining room and the nurse was informed that he was back. V2 said the facility was not aware of R1's POA's wishes for R1 not to left in his room in his wheelchair unattended. On 1/12/23 at 4:30 PM, V2 said she feels R1 was safe to be in his room unsupervised in his wheelchair. V2 said the staff had parked the wheelchair near R1's bed. V2 said R1 has no trunk control so he leaned forward to lean against the bed and that is how he fell to the floor. V2 said she was not aware R1 would lean out of his chair onto his bed so at that time he

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S9999	Continued From page 9 was not safe to be in his room in his wheelchair by himself. V2 said after R1's fall they dropped the seat of his wheelchair down so he would be a safer position while in the chair and staff will put fall mats down next to the bed if R1 is in the bed and next to his wheelchair if he is in his wheelchair. The facility's policy with revision date of 9/17/19 titled Fall Policy showed, "Purpose: 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. The Fall Management Program promotes safety, prevention, and education of both staff and residents. Policy: the facility shall ensure that a fall management program will be maintained to reduce the incidence of falls and risk of injury to the resident and promote independence and safety..." "B" Statement of Licensure Violations II of II: 300.610a) 300.1210a) 300.1210b) 300.1210d)5) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The	S9999		

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S9999	Continued From page 10 policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:	S9999		

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S9999	Continued From page 11 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to implement interventions to prevent pressure ulcers, failed to identify pressure injuries, and failed to accurately assess pressure injuries for a resident at risk for developing pressure ulcers for 1 of 3 residents (R1) in the sample of 4. These failures resulted in R1 developing a pressure ulcer to his sacrum which the facility assessed as a stage 3 on 1/1/23, corrected staging on 1/3/23 to a stage 2, and was assessed by the acute care hospital wound care nurse on 1/3/23 as an unstageable pressure injury with areas of eschar and slough. The facility failed to identify wounds to R1's bilateral heels which were identified at the acute care hospital during upon admission on 12/11/22 and again on readmission to the acute care hospital on 1/3/23. The findings include: R1's medical record showed he was admitted to the facility on 11/11/22 with diagnoses to include disorders of electrolyte and fluid balance, muscle weakness, unsteadiness on feet, cognitive	S9999		

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S9999	Continued From page 12 communication deficit, apraxia (neurological movement disorder), and dementia. R1's facility assessment dated 11/17/22 showed he has severe cognitive impairment and requires extensive to total assist for all activities of daily living. R1's pressure risk assessment complete 11/11/22 showed he was at risk for developing pressure ulcers. On 1/11/23 at 1:54 PM, V12 (R1's Daughter) said she was at the facility visiting her father on 1/3/23 when she saw a tube of cream on his bedside table. V12 said there was a CNA (Certified Nursing Assistant) in the room at the time and she asked what the cream was for. V12 said the CNA responded saying, "He has bedsores, didn't they tell you?" V12 said she met with the DON (Director of Nursing) on that same day and the DON told her she was not aware of [R1] having bedsores until that conversation with V12. R1's complete care plan was reviewed with no evidence of a care plan initiated for pressure prevention measures. R1's acute care hospital documents from his 12/11/22 through 12/13/22 hospital stay showed R1 was admitted to the hospital on 12/11/22 with a pressure ulcer to his sacrum, left heel, and right heel. R1's eTAR (electronic Treatment Administration Record) for December 2022 showed no dressing changes to any pressure wounds to R1's bilateral heels or sacrum. R1's January 2023 eTAR showed no treatments to R1's bilateral heels and a new treatment started for a pressure injury to R1's sacrum on 1/2/23. R1's nursing note dated 1/1/23 at 11:50 PM	S9999		

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	IL6002299	A. BUILDING: _____ B. WING _____	C 01/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL PINES REHAB & HCC	335 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014

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S9999	Continued From page 13 showed, "Coccyx pressure, Stage 3; Cleanse with wound cleanser, skin prep peri-wound. Apply Calcium alginate to wound bed. Cover with large bordered gauze." R1's 1/3/23 (the day the wound was identified) Daily Skilled Note showed, ".... Skin Condition... NONE." R1's 1/3/23 (the day the wound was identified) Skin Check Assessment showed, "no new changes this week." R1's 1/3/23 Skin & Wound Evaluation showed a new pressure ulcer measuring 3.9 cm x 6.0 cm with a moderate amount of serosanguineous drainage was present. R1's medical record showed he was readmitted to the acute care hospital on 1/3/23. R1's acute care hospital documentation dated 1/3/23 showed R1 had pressure wounds to his sacrum, right heel, and left heel on admission. R1's acute care hospital, wound care consult, dated 1/4/23 showed R1 had a deep tissue injury to his right heel measuring 3 cm x 2.6 cm, a stage 1 pressure injury to his left heel measuring 3 cm x 5 cm, and an unstageable pressure wound to his sacrum measuring 6.5 cm x 8.5 cm x 0.1 with areas of eschar and slough. R1's nursing note dated 1/3/23 at 12:23 PM and entered by V5 (Wound Care Nurse) showed, "Correction to staging - this is a stage 2 pressure/coccyx per WCN (Wound Care Nurse) assessment. Peri-wound is pink, no edema noted. Wound bed is pink, moderate serosanguinous drainage. Cleansed with wound cleanser, pat dry. No obvious signs or symptoms of tenderness noted. Skin prep to periwound.	S9999		

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S9999	Continued From page 14 Applied calcium alginate to wound bed. Covered with bordered gauze dressing. Updated floor nurse." On 1/12/23 at 1:20 PM, V5 (Wound Care Nurse) said skin checks are done weekly. If the nurse finds a new skin condition they would measure it, sent the information to the provider, enter a treatment order, and enter the new skin condition into the facility's risk management system. V5 said the nurse would also be expected to notify the family of the new area. V5 said R1's skin conditions consisted of lacerations with sutures and then recently a new pressure ulcer to his sacrum. V5 said she started the low air loss mattress for prevention at the time the order was entered into the electronic medical record after the wound was identified. V5 said other pressure prevention interventions were frequent checks for incontinence and frequent repositioning. V5 said she is not sure if R1 needed anything more for pressure prevention because it was a surprise to them when they identified the wound. V5 said the pressure ulcer is "unfortunately facility acquired and likely caused by the resident being "stiff" while turning side to side, gravitating back to a supine position, and not quite enough effort by staff with turning and repositioning." V5 said she was not aware R1 had pressure injuries to both of his heels. V5 said she did not notify the power of attorney regarding R1's pressure injury. On 1/12/23 at 4:30 PM, V2 (Director of Nursing/DON) said she was not aware R1 had any pressure ulcers until 1/3/23 when she was approached by V12 (R1's daughter) when he was having a change of condition and being sent to the hospital for evaluation. V2 said on admission and readmission a skin assessment is done to identify current skin conditions and determine risk	S9999		

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S9999	Continued From page 15	S9999		

for pressure ulcers. V2 said R1 should have a care plan in place for pressure prevention. V2 said she would expect nursing staff to identify new skin conditions when they appear as redness to the skin because they should be doing skin checks every time they do incontinence care and when they give showers. V2 said it is important to put interventions in place prior to wounds developing into advanced stages. V2 said she would expect to be notified of new skin conditions and would expect the power of attorney to be notified of new skin conditions. V2 said notifying the family regarding new treatments and conditions is part of providing caring for the resident.

The facility's policy with revision date March 2022 titled Pressure Ulcer/Pressure Injury Prevention showed, "... A facility must: Identify whether the resident is at risk for developing or has a pressure ulcer/pressure injury upon admission and thereafter; Evaluate resident specific risk factors and changes in the resident's condition that may impact the development and/or healing of a pressure ulcer/pressure injury; Implement, monitor and modify interventions to attempt to stabilize, reduce or remove underlying risk factors;... The first step in prevention of pressure ulcers/pressure injuries is the identification of the resident at risk for developing pressure ulcers/pressure injuries. This is followed by the implementation of appropriate individualized interventions and monitoring for the effectiveness of the interventions. An individual plan of prevention will be developed to meet the needs of the resident. It will include the consideration of mechanical support surfaces, nutrition, hydration, positioning, mobility, continence, skin condition and overall clinical condition of the resident as well as the risk factors as they apply to each

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S9999	Continued From page 16 individual... Based on evaluation, the need for reassessment and further changes to the individual resident's plan of care will be determined and acted upon." "B"	S9999		