STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000327	A. BUILDING: _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ROLLING MEADOWS,THE	4225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008

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S 000	Initial Comments Complaint Investigations: 2094721/IL123955 2092606/IL121712 2097716/IL127276 2099010/IL128700	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)6) 300.1220 b)3) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

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:
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.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These regulations are not met as evidenced by:

Based on observations, interviews, and record review, the facility failed to implement the fall prevention policy, failed to update and modify a

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S9999	Continued From page 2	S9999		

resident's plan of care, and failed to provide supervision for high risk fall residents. This failure resulted in R3 falling and sustaining an occipital bone fracture.

This applies to 1 of 3 residents (R3) reviewed for fall from a sample of 11.

Findings include:

Record review of an incident report, dated 4/16/20, documented R3 had a fall in the dining room on 4/16/20. Record review on fall care plan indicates that the facility didn't update the fall care plan to prevent further falls through incorporating the root cause of the fall.

Record review on an incident report, dated 5/13/2020, documented R3 had a fall in the hallway, and ended up having a bump on the front of her left forehead. On 1/11/2021 at 12:03 PM, V2 stated, "On 5/13/20, I don't think anybody witnessed the fall. R3 was on high risk for fall, and somebody should have supervised/monitor the resident."

Record review on fall log, the incident report, and reportable indicates R3 had a fall in the hallway on 6/2/20 with 2 centimeters (cm) skin laceration at the back of her head with a small amount of bleeding. The resident was unresponsive with eyes open and breathing. Record review on hospital record on CT (Computerized Tomography) of the brain indicates the progression of the intracranial hemorrhage.

Record review on fall log, the incident report, and reportable indicates R3 had an unwitnessed fall on 7/31/20 and was sent out to the local hospital. Record review on hospital record on CT of the

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S9999	Continued From page 3 brain, dated 7/31/20, indicates nondisplaced right occipital bone fracture. Record review on R3's fall risk assessment, dated 6/9/20 (55), 7/31/20 (65), 6/2/20 (40) 7/31/20 (65), indicates that R3 was on high risk for fall (any score > 44). On 1/5/2021 at 12:40 PM, observed dementia unit activity/dining room with sixteen residents, including R3, with no staff supervision. On 1/5/2021 at 12:45 PM, observed V5 (Certified Nursing Assistant) wheeling a resident from the hallway to the dining/activity room. V5 stated, "I am supposed to be here, But one of the residents walked out of the dining room, and I didn't see her walking out. I went to the hallway to bring her back." On 1/5/2021 at 12:47 PM, V3 (nurse) stated, "Somebody should be there to monitor the residents in the dining room closely, as some of them have multiple falls." On 1/6/2021 at 11:41 AM, V2 (Director of Nursing) and V9 (Fall coordinator) stated, "Residents on fall precaution always need to be supervised. V5 should have to call somebody to stay with residents while he went to bring the other resident back to the room." On 1/7/2021, V2 stated, "Post fall investigation should reflect root cause and care plan should have been updated. Our restorative nurse was supposed to update the care plan. She should have nailed down the root cause and update the care plan. She was not doing her job, and I let her go." On 1/11/2021 at 12:03 PM, V2 stated, "The staff was there but wasn't able to stop fall."	S9999		

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S9999	Continued From page 4 On 1/7/2021 at 2:30 PM, V7 (Attending Physician) stated, "R3's intracranial hemorrhage from the fall that happened on 6/2/20 wasn't bad, and she didn't have to go through any brain surgery." On 1/7/21 at 2:30 PM, V7 stated, "R3 has dementia and is vulnerable for fall. Her bones are brittle due to her medical conditions, and the facility should not leave those residents unattended." On 1/11/2021 at 12:03 PM, V2 stated, "On 6/2/20, R3 had an unwitnessed fall, and somebody should have supervised R3 while she was in the hallway." On 1/11/2021 at 12:03 PM, V2 stated, "On 7/31/20, R3 had an unwitnessed fall, and somebody should have monitored R3 closely to prevent fall." Facility presented Fall Reduction Program, dated 6/16/2020, document: All residents will receive adequate supervision, assistance, and assistive devices to prevent falls. The care plan is updated with any new interventions for every fall based on the root cause. (B)	S9999		