STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014906	A. BUILDING: _____ B. WING _____	C 11/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF HILLSIDE,THE	4600 NORTH FRONTAGE ROAD HILLSIDE, IL 60162

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S 000	Initial Comments Complaint Investigation 2198142/IL139882	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)3) 300.1210 d)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 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 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. 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. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to prevent one resident (R2) who was dependent on staff for turning, repositioning, and incontinent cares, and at risk for developing pressure ulcers, from developing an unstageable pressure ulcer on sacrum. This failure resulted in R2 being admitted to the hospital for Sepsis secondary to urinary tract infection and sacral wound. This failure affected 1 (R2) of 3 residents reviewed for pressure ulcers. Findings include: R2 is 65 year old with diagnosis including. but not	S9999		

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S9999	Continued From page 2	S9999		

limited to: Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant hand, Osteoarthritis, Encounter for Palliative Care, Major Depressive Disorder, Diabetes Mellitus, Hyperlipidemia, Hypertension, Cerebral Infarctions, and Dysphagia.

R2 was admitted to the facility on 8/19/21, and transferred and admitted to the hospital on 10/27/21.

Review of R2's Assessment, dated 8/26/21, note R2's cognitive status is moderately impaired. Functional status notes R2 requires total dependence from staff for bed mobility, toilet use, and extensive assist for dressing. R2 is documented to have limitation in range of motion to one side. Skin conditions notes R2 is at risk for developing pressure ulcers and does not have pressure ulcers on or before 8/26/21.

Review of R2's Risk Assessment for skin breakdown from 8/19/21 thru 10/5/21, all indicate a score of 13, Moderate Risk.

R2's care plan, initiated on 8/30/21, notes R2 has activity of daily living self care performance deficit related to Hemiplegia and Hemiparesis following Cerebral Infarction. The intervention notes R2 requires extensive assistance to turn and reposition in bed frequently and as necessary.

Review of R2's progress notes, dated 10/3/21, note R2 crying. R2's daughter reported R2 is weak.

Review of Follow Up Question Report, dated 10/6/21, notes V20 documented a new skin condition.

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S9999	Continued From page 3 Review of R2's Progress Notes on 10/6/21 do not include a skin condition. No Assessment is in the electronic record for 10/6/21 related to R2's skin. Review of R2's progress notes, dated 10/6/21, note R2's daughter stated she planned to visit R2 more often since R2 is not feeling well. Review of R2's Wound Assessment, dated 10/12/21, notes at 10:00AM, R2 has a pressure ulcer on sacrum 85% Slough, measured 8.0cm length x 10.0cm wide. Review of R2's care plan intervention, initiated on 10/12/21, notes encourage small frequent position changes. However, staff and assessments indicate R2 was dependent on staff for positioning. R2's Assessment, dated 10/12/21, notes R2's cognition is severely impaired, and R2 requires extensive assist from staff to turn and position. Review of V21's Wound Care Notes, dated 10/27/21, measured R2's wound as 7.5cm length x 10cm width and the wound is deteriorating. Sacral debridement was performed. R2's Orders (provided in screen shot format by facility) note on 10/27/21, "Send (R2) to emergency room for altered mental status and leukocytosis." Review of R2's hospital record Progress Notes, date of admission is 10/27/21, and Reason for Admission is Sepsis secondary to urinary tract infection and sacral wound. Emergency Department course: patient was febrile with temperature 101, tachycardic.	S9999		

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S9999	Continued From page 4 On 11/5/21 at 12:53PM, V11, Wound Nurse, said, "A Certified Nursing Assistant (CNA) asked me to look at R2. When I looked, R2 had an unstageable wound on (R2's) bottom. It had slough and I could not see past the slough to know the depth." On 11/5/21 at 3:02PM, V15, Certified Nursing Assistant (CNA), said R2 was totally dependent on staff for cares, and needed to be repositioned by staff. V15 said R2 stayed in bed and was incontinent of urine. On 11/9/21 at 10:25AM, V17, CNA, said V17 was assigned to R2 on 10/12/21, and was turning R2 and saw R2 had a patch on R2's bottom and it was soiled. V17 said, "The patch looked like a dressing and it was soiled and I took it off." V17 said V17 then went to get the nurse, and reported the wound. V17 said, "This is the first time I had seen this area on R2." V17 said R2 was being turned every 2 hours. V17 said 2 hours is the standard for repositioning residents. On 11/9/21 at 10:45AM, V18, Licensed Practical Nurse, said on 10/11/21, V18 worked the night, 11:00PM- 7:00AM shift, and checked R2's skin. V18 said R2's skin was clear when V18 checked R2, and there was not a dressing on R2's bottom. V18 said it is rare to see an unstageable ulcer develop in just a few hours. On 11/9/21 at 11:57AM, V11 said on 10/12/21, V11 did not see a dressing on R2, and the CNA did not tell V11 she removed a dressing on R2. V11 said if a resident begins to fail, they can develop a wound quickly. V11 said the standard to turn and position a resident is every 2 hours. V11 said after R2 developed the wound, R2 could have been turned more frequently.	S9999		

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S9999	Continued From page 5 On 11/9/21 at 12:51PM, via phone interview, V20, CNA, said V20 documents resident's skin condition in the computer charting system. V20 said on 10/6/21, R2 had a small scratch or something on R2's back side, and that was why V20 documented "yes" for new skin area. On 11/9/21 at 1:38PM, V2, Director of Nursing, said "I called (V20) today. (V20) said no one talked to (V20) prior to today about (V20's) documentation on 10/6/21 for (R2)." On 11/9/21 at 1:50PM. via phone interview. V21, Wound Nurse Practitioner, said slough is soft necrotic tissue. V21 said a pressure ulcer can develop in a couple of hours. V21 said R2 was anemic based on lab results from 10/3/21. and R2 had a low albumin protein level lab on 10/4/21. V21 said low labs levels contribute to skin breakdown. V21 said with incontinent care, the staff may have noticed skin breakdown prior to it becoming sloughed. V21 described the wound as bigger than a ping pong ball and smaller than a baseball. V21 said V21 first saw R2's wound on 10/14/21 and it measured 7.0 cm length x 8.5 cm width. On 11/9/21 at 2:18PM, via phone interview, V22, MDS Nurse, said R2's status was discussed because of R2's intravenous fluid status on 10/6/21, and "(R2) seemed more depressed. We decided to do a significant change assessment on (R2)." V22 said, "During the assessment period, we found (R2) had declined cognitively, as well." V22 said on 10/12/21, the Assessment Reference Date, it was reported R2 had a pressure ulcer. The facility provided policy titled Comprehensive	S9999		

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S9999	Continued From page 6 Resident Centered Care Plans, review date 3/20/21, states Developing Care Plan: 3c. Each planned intervention will be specific and include parameters for frequency and time schedules. The facility provided policy titled Wound Prevention, review date 3/20/21, states "The purpose of this program is to assist the facility in the care, services and documentation related to the occurrence, treatment, and prevention of pressure as well as, non pressure related wounds." (B)	S9999		