STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012686	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ELK GROVE, THE	1920 NERGE ROAD ELK GROVE VILLAGE, IL 60007

(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
S 000	Initial Comments Complaint Survey: 23710190/IL167512	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)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 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	S9999		

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.

These Requirements were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure bed heights were at the lowest level and failed to provide two staff assist to prevent injuries. As a result, R1 and R3 sustained left and right hip fractures, respectively, and were admitted to the hospital.

This applies to 2 of 5 residents (R1 and R3) reviewed for falls in a sample of 14.

Findings include:

1. R1's progress notes showed R1 had two falls on 03/23/2023 and one on 03/24/2023 and 03/30/2023. R1's Minimum Data Set dated 11/03/2023 showed R1 was dependent on her daily living activities and required two or more assistance for daily living care activities. The universal fall precaution in part showed "Place the hospital bed in a low position when a patient (Resident) is resting in bed."

On 12/14/2023 at 09:32, V9 (R1's Physician) said he had known R1 for a long time and her health

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S9999	Continued From page 2	S9999		

conditions were deteriorating. V9 said R1 was bedbound and required two assists.

On 12/14/2023 at 09:55 AM, V19 (Director of Rehab Therapy) said R1 was a total assist and was confused and has a history of high fall risk. V19 said R1 required two staff assistants for all her daily care activities, and her bed should be as low as possible to minimize the impact of falls.

On 12/13/2023, V10 (Certified Nursing Assistant) said on 11/23/2023 at night, he changed R1's colostomy bag, and R1's linen was soiled. V10 said when he leaned to reach for clean linen to change her, R1 rolled over the left side of the bed and fell on the floor. V10 said he thought he needed to use two assistances only for mobility/transfer and said, "Now I know."

On 12/12/2023 at 01:22 PM, R1 was in bed and was not interviewable. R1's bed height was not at a lowest level,writer showed V4 (Registered Nurse) the level of R1's bed, and V4 said R1's bed should have been at a lower level.

The Hospital Physician's history and physical report dated 11/23/2023 at 9:28 AM showed R1's colostomy bag was being changed around midnight when she sustained a witnessed fall as she rolled over from her bed to the floor. R1 was admitted to the intensive care unit (ICU), and R1's X-ray of her left femur was positive for hip fracture (intertrochanteric hip fracture), which was acutely displaced. R1 had a surgery on 11/28/2023.

A review of the face sheet showed that R1 was a 78-year-old initially admitted on 03/06/2023 and readmitted to the facility multiple times, including on 03/10/2022 with diagnoses including

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colostomy status, diabetes mellitus, hypertension, schizophrenia, anemia with chronic kidney disease, and retention of urine.

A review of V18's (Registered Nurse) progress notes on 11/23/2023 at 01:15 AM showed that V18 heard a noise coming from the room; upon entering the room, the resident on her left side and she noted a small amount of blood from the left outer lining of the ear and paramedics were called. Progress noted further showed that when paramedics transferred R1 from the floor to the gurney, R1 said her left leg and back were hurting.

On 12/12/2023, V2 (Director of Nursing) at 3:00 PM, and on 12/13/2024 at 9:37 PM, V18(Registered Nurse) said V18 and V10 (Certified Nursing Assistant) were assigned for R1 and V10 should have called for help. V2 said the facility follows universal fall prevention precautions. V18 said bedbound and fall-risk residents' beds should be as low as possible while in bed and use two staff assistance for activities of daily living care. V2 said R1 and R3's fall incidents with injuries were reported to IDPH.

2. R3's hospital Physician progress notes dated 11/24/2023 showed R3 presented to the hospital on 11/20/2023 after a fall, was diagnosed with a right hip displaced femoral neck fracture, and had had surgery.

On 12/12/2023 at 01:12 PM, R3 was in bed and was interviewable. V12 (R3's POA, Power of Attorney) was by R3's bedside. R3's bed height was not in the lowest level. R3 and V12 said R3 had a fall a few weeks ago and had a fracture. V12 said he visits R3 frequently and does not see his bed in the lowest level. R3 said during the fire

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S9999	Continued From page 4 alarm check, he got scared, tried to get up, and fell from the bed to the floor. R3 said he did not think his bed was at a lower level. At 1:12 PM, V3 (Registered Nurse) witnessed the bed height at a higher level and said R3 is a high fall-risk resident, and the bed should be at a lower level while he is in bed. On 12/14/2023 at 09:55 AM. The facility's fall prevention and management policy, dated October 2021, showed in part, "All residents and patients considered at risk for falling regardless of fall risk score. Universal fall precaution (Facility protocol) interventions will be implemented to all." (A)	S9999		