STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014666	A. BUILDING: _____ B. WING _____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD ST CHARLES, IL 60174

(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 Investigation: 2476469/IL176765	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.620d)1) 300.1850o) 300.1850p) 300.3300d)2) 300.3300e)1)2)3)4)5) 300.3300k) 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 300.620 Admission, Retention and Discharge Policies d) No person shall be admitted to or kept in the facility: 1) Who is at risk because the person is reasonably expected to self-inflict serious physical harm or to inflict serious physical harm on another person in the near future, as determined by professional evaluation;	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014666	A. BUILDING: _____ B. WING _____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD ST CHARLES, IL 60174

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S9999	Continued From page 1	S9999		

Section 300.1850 Other Resident Record Requirements
This Section contains references to rules located in other Subparts that pertain to the content and maintenance of medical records.
o) Any resident transfer or discharge mandated by the physical safety of other residents shall be documented in the resident's medical record as required by Sections 300.3300(d) and (g) of this Part.

p) Summaries of discussions and explanations of any planned involuntary transfers or discharges shall be included in the medical record of the resident that is to be involuntarily transferred or discharged, as described in Section 300.3300(j) of this Part.

Section 300.3300 Transfer or Discharge
d) Involuntary transfer or discharge of a resident from a facility shall be preceded by the discussion required under subsection (j) of this Section and by a minimum written notice of 21 days, except in one of the following instances:
2) When the transfer or discharge is mandated by the physical safety of other residents, the facility staff, or facility visitors, as documented in the clinical record. The Department and the State Long Term Care Ombudsman shall be notified prior to any such involuntary transfer or discharge. The Department will immediately offer transfer, or discharge and relocation assistance to residents transferred or discharged under this subsection (d)(2), and the Department may place relocation teams as provided in Section 3-419 of the Act; or (Section 3-402(b) of the Act)

e) For transfer or discharge made under subsection (d), the notice of transfer or discharge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014666	A. BUILDING: _____ B. WING _____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD ST CHARLES, IL 60174

(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 page 2	S9999		

shall be made as soon as practicable before the transfer or discharge. The notice required by subsection (d) of this Section shall be on a form prescribed by the Department and shall contain all of the following:

1) The stated reason for the proposed transfer or discharge; (Section 3-403(a) of the Act)

2) The effective date of the proposed transfer or discharge; (Section 3-403(b) of the Act)

3) A statement in not less than 12-point type, which reads:

"You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may file a request for a hearing with the Department of Public Health within 10 days after receiving this notice. If you request a hearing, it will be held not later than 10 days after your request, and you generally will not be transferred or discharged during that time. If the decision following the hearing is not in your favor, you generally will not be transferred or discharged prior to the expiration of 30 days following receipt of the original notice of the transfer or discharge. A form to appeal the facility's decision and to request a hearing is attached. If you have any questions, call the Department of Public Health or the State Long Term Care Ombudsman at the telephone numbers listed below."; (Section 3-403(c) of the Act)

4) A hearing request form, together with a postage paid, preaddressed envelope to the Department; and (Section 3-403(d) of the Act)

5) The name, address, and telephone number of the person charged with the responsibility of supervising the transfer or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014666	A. BUILDING: _____ B. WING _____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD ST CHARLES, IL 60174

(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 page 3	S9999		

discharge. (Section 3-403(e) of the Act)

k) The facility shall offer the resident counseling services before the transfer or discharge of the resident. (Section 3-409 of the Act)

This REQUIREMENT is not met as evidenced by:

Based on interview and record review the facility failed to provide a safe discharge for a resident with insulin-dependent diabetes and end-stage renal failure, requiring hemodialysis. This failure resulted in R1 being discharged from the facility and sent to a homeless shelter without the shelter's knowledge or ability to accept and care for the resident. Because of the resident's homelessness, R1 was transported to the local hospital, where he remained as of August 22, 2024, awaiting placement in another long-term care facility. This applies to 1 of 3 residents (R1) reviewed for discharge in the sample of 3.

The findings include:

On August 18, 2024 at 6:42 PM, R1 said, "On August 14, I was called to the front of the building, and they said they had to talk to me. I went up to the front and the police were up front, waiting for me. They handed me discharge papers. They said something about involuntary discharge for being a danger to myself and others. They said I was drunk, which was nonsense. I have a doctor's order for alcohol. They said there was a ride waiting for me, and I had to get my stuff together. This was the first time I'd heard they were going to discharge me. There was a van out in front, and they didn't tell me where I was going. I thought I was going to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014666	A. BUILDING: _____ B. WING _____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD ST CHARLES, IL 60174

(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 page 4	S9999		

another nursing home. We started driving, for what seemed like a long time, and I asked the driver where we were going, and he said Joliet. I had a couple of boxes with me that were each measured probably 2 feet by 3 feet, and my wheelchair. We pulled up, and I couldn't get out of the van without help. Someone came out of the building and said this is a homeless shelter and they weren't expecting me. One of the shelter's administrators called the facility where I had just come from, and the shelter's administrator was told administration made this decision. So, I didn't know what else to do. The shelter couldn't accept me, and I had nowhere else to go. I called 911 to get help from the police. I ended up agreeing to go to the hospital because there was nowhere else for me to go. I've been at the hospital ever since and receiving my dialysis here in the hospital."

The EMR (Electronic Medical Record) shows R1 was admitted to the facility on November 14, 2022. The EMR continues to show R1 was involuntary discharged from the facility on August 14, 2024. R1 had multiple diagnoses including, diabetes, end-stage renal disease, acute pulmonary edema, heart failure, acute respiratory failure, anxiety disorder, anemia, alcohol abuse, and glaucoma.

Hospital records provided to the facility prior to R1's admission to the facility dated November 4, 2022 show R1 had anxiety, uncontrolled diabetes, alcohol abuse, cigarette smoking, acute psychiatric concerns, aggressive behavior, paranoid delusions, suicidal and homicidal remarks in the ER (Emergency Room). He threatened to shoot up the shelters and shoot himself because he was tired of his illness. He was belligerent with the healthcare team and had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014666	A. BUILDING: _____ B. WING _____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD ST CHARLES, IL 60174

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S9999	Continued From page 5	S9999		

to be placed in restraints.

R1's MDS (Minimum Data Set) dated June 12, 2024 shows R1 was cognitively intact, used a walker or wheelchair for mobility, and was able to perform all ADLs (Activities of Daily Living) independently. R1 was always continent of bowel and bladder. The MDS continues to show R1 participated in the MDS assessment and goal setting, did not have active discharge planning occurring to return to the community, and did not want to talk to someone about the possibility of leaving the facility and returning to live and receive services in the community.

Facility documentation shows R1 started on hemodialysis in January 2024. R1 received hemodialysis outside of the facility three times a week.

Facility documentation shows the following order for R1 dated June 20, 2024 and discontinued on August 14, 2024 (R1's date of discharge): "May have alcohol."

The facility's Notice of Involuntary Transfer or Discharge and Opportunity for Hearing dated August 14, 2024 shows R1 was discharged to a homeless shelter over 35 miles away from the facility on August 14, 2024, due to "the health of individuals in the facility would otherwise be endangered as documented by a physician in your clinical record." The IVD (Involuntary Discharge) notice continues to show, "As discussed with [R1] on August 14, 2024, and as documented in your clinical record pursuant to Section 3-408 of the state law, the reason for the proposed transfer or discharge is: the physical safety of other residents, the facility's staff or visitors ... The effective date of the proposed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014666	A. BUILDING: _____ B. WING _____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD ST CHARLES, IL 60174

(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 page 6	S9999		

transfer or discharge is August 14, 2024." The IVD notice was signed by V1 (Administrator) on August 14, 2024.

On August 14, 2024 at 2:45 PM, V1 (Administrator) documented, "Involuntary Discharge was explained and issued with witnesses. Resident verbally agreed to pack his own belongings and donate whatever he leaves. Medications and prescriptions given to resident. Explained that his personal vehicle would need to be removed by the end of day 3 which is 8/17/24. Resident verbalized understanding and placed some of his belongings in his personal vehicle. Entire incident witnessed by two [local] police officers, SSD (Social Service Director), DON (Director of Nursing, Regional SS (Social Service) and Maintenance Director. Resident picked up by [ride company] at 2:50 PM and left facility."

On August 14, 2024 at 5:03 PM, V3 (SSD) documented, "[Local] Police department (near homeless shelter) contacted the facility and call was transferred to this writer. Police officer inquired, "why was [R1] placed in a vehicle and sent to [homeless shelter]." This writer informed because he received an Involuntary Discharge from the facility, please request to see the document. Officer stated, "thank you" and disconnected the call."

On August 14, 2024 at 5:05 PM, V3 (SSD) documented, "[Homeless Shelter] case manager contacted this writer and inquired, "why was [R1], discharged to our shelter?" Replay was [R1] received an Involuntary discharge, he has the document, please request to review." Case manager explained, "We do not accept nursing home residents, typically the process is we review the clinicals." Case manager informed this writer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014666	A. BUILDING: _____ B. WING _____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD ST CHARLES, IL 60174

(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 page 7	S9999		

he stated he is going to the hospital."

On August 19, 2024 at 11:15 AM, V1 (Administrator) said, R1 was extremely unhappy and manipulative. "He calls staff names, he will leave the facility without permission, he orders his own ride share, he has a drinking problem and returns late, and we believe he was intoxicated. He takes other residents out to go out on the sidewalk and go to the store. (R2, R3, R4). He threatens to call (state surveying agency) on us. He would throw parties on the patio and invite people and they came through the back gate. We know he has a problem. Every agreement he makes he turns around and breaks it. Leading up to that day (August 14), he was encouraging the other residents to go out, and being intoxicated. His physician was trying to convince him to go to detox or stop engaging in this behavior. We have not tried petitioning him out for a psych evaluation since I started here in October 2023. He wants to get an apartment. The regional team combed through the records, and they showed he came from a shelter and just decided that would be the best place for him to go, or the only place to go. He left the facility in a wheelchair. He goes to dialysis on Tuesday, Thursday, and Saturday. We sent him to the homeless shelter, and [R1] got there and said he did not know why he was there and that he did not know he was going there. He said he did not consent to going there. He was a danger to some other residents (R2, R3, and R4) directing them to do what they wanted to do."

Facility documentation shows R2, R3, and R4 are cognitively intact residents.

On August 19, 2024 at 11:45 AM, V10 (Senior Social Worker) said, "I was looking at different

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014666	A. BUILDING: _____ B. WING _____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD ST CHARLES, IL 60174

(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 page 8	S9999		

shelters for [R1]. To be eligible you have to experience homelessness, and once he got the involuntary discharge, he was homeless. There was an evening he came back to the facility intoxicated, and he was manipulating other residents to drink. He was becoming more and more challenging with disruptive behavior. He had an order from the physician to be able to drink alcohol."

On August 7, 2024 at 3:09 PM, V13 (Psych Nurse Practitioner/NP) documented: "[R1] is seen today per request of the facility Administrator and staff. [R1] is known to our service, last seen in March of this year for verbally inappropriate comments and disruptive behaviors. He is cognitively intact x 4 and is knowledgeable about his medical issues and medications. [R1] is on HD (Hemodialysis) 3x/weekly at an outside center and has returned from dialysis heavily intoxicated from both ETOH (alcohol) and cannabis. [R1] is allowed to have three beers daily per his primary MD at the facility however, he is sharing his alcohol with other residents who are cognitively impaired and should not be drinking ETOH with their medical issues and dementia. [R1] is manipulative and tries to turn other residents who are in lower functioning against the staff. He bribes them with alcohol or cannabis and tells them that they do not have to listen to the staff or follow any rules. He calls the State to report on the facility, threatening to "bust them for being a big dump." [R1] does not need to be in the care of a facility, can be independent with all his ADLs, and stays at the facility due to his homelessness. He has no family relations and has a history of SUD (substance use disorder) and battery towards his spouse. He has always denied any of the above actions and refuses any medications for mood. ...Mood: euthymic mood and congruent affect were seen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014666	A. BUILDING: _____ B. WING _____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD ST CHARLES, IL 60174

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S9999	Continued From page 9	S9999		

on exam. Thought processes and associations: thought processes showed associations/processes/abstractions WNL (within normal limits). Thought content: Patient did not endorse suicidal ideation, homicidal ideation, violent ideation, auditory/visual hallucinations, or delusions. Insight/judgement: The patient's insight and judgement are appropriate. Assessment: This patient has multiple psychiatric complexities and would benefit from continued management with monitoring of mood and behavior. Will titrate medications based on current symptom progression. Pharmacologic/Non-Pharmacologic Interventions: [R1] refuses any psychotropic medications and does not follow facility rules, continues to use alcohol and smoke cannabis. He is disruptive and manipulates and poses a significant danger to the other residents and staff at the facility."

The facility does not have documentation to show R1 had a positive alcohol or drug test.

On August 19, 2024 at 1:14 PM, V13 (Psych NP) said, "I saw him on August 7, 2024. I had not seen him since March 2024. When he first came to the building he had been living in his car and had been suicidal. He is alert and oriented. The current problems are new, maybe since he started going to dialysis (January 2024). I guess he was coming back to the facility intoxicated. I never saw him intoxicated. He is very bright, he is smart, he knows what he is doing. The facility felt they were held hostage by his behavior. Where do you put someone like this? We have never petitioned him for a psychiatric evaluation. I guess if you are giving drugs or alcohol to other residents who cannot make decisions that could be a problem, though I do not believe [R2], [R3], or [R4] are cognitively impaired. I think the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014666	A. BUILDING: _____ B. WING _____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD ST CHARLES, IL 60174

(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 page 10	S9999		

Medical Director allowed [R1] to have alcohol and that escalated other behaviors. He created a posse of other residents who don't want to follow the rules. I said he was a danger to the other resident for giving them alcohol. That was the danger. He wasn't really a problem, he was annoying. My notes and the letter I wrote were a request from the facility. That was my first time writing something like this." V13 continued to say she had not seen R1 intoxicated or in the possession of alcohol or cannabis.

On August 20, 2024 at 3:59 PM, V5 (Assistant Director of Nursing/ADON) said, "When [V13] (Psych NP) wrote that note on August 7 and said [R1] was a danger to himself and others, nothing was implemented to protect other residents from him. We did not do a one-to-one sitter or send him to dialysis with a facility staff member. There was no frequent monitoring."

On August 20, 2024 at 1:03 PM, V11 (Medical Director/Physician) said, "[R1] was my patient. I think the bigger problem was he was drinking excessively and not following the house rules about being intoxicated and influencing other resident with drinking. He was kind of acting like a college student. I can agree that the resident was admitted to the facility in November 2022 with the same issues and the facility was aware of his alcoholism and behaviors at that time. I know the NP wrote a note on August 7 that showed he was a danger to himself, and others and we waited seven days to involuntarily discharge him and give him the notice. We looked into all of this with legal and the social worker and I think the delay in discharging him was in that process. We wanted to make sure we made proper arrangements for him and coordinated his care. They should have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD ST CHARLES, IL 60174

(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 page 11	S9999		

coordinated his care with the receiving facility. I did not take any involvement on how it was done. I expect the facility to follow the Federal regulations for involuntary discharges, and to follow the facility's policy for involuntary discharge. I was not aware [R1] was dropped at the homeless shelter or that 911 had to be called or that he was sent to the hospital and is still awaiting placement in a facility. It was not the intention to discharge him to the streets. [R3], another resident currently residing at the facility, is making poor choices as well. If he doesn't improve on his act, we have to make a choice for him." When asked about hospital records dated November 2022 showing R1 had similar behaviors in the hospital, prior to his admission to the facility, including alcohol abuse and belligerence towards medical staff, and the need for restraints in the hospital, V11 admitted the facility was aware and admitted the resident to the facility in November 2022 knowing that information.

On August 19, 2024 at 12:32 PM, V3 (SSD) said, "The decision to involuntarily discharge [R1] was made at the Regional level. I did not have a conversation with the homeless shelter, and I did not choose that place. It was 5:00 PM on August 14, and the shelter called and said they could not keep him. I cannot speak to why he was not discharged a week earlier, on August 7, 2024 after the psych NP (Nurse Practitioner) (V13) saw him and said he was a danger to himself and others."

On August 20, 2024 at 1:43 PM, V9 (Hospital Case Manager) said, "[R1] is still in the hospital and we are still trying to find him placement. We sent out 46 referrals. 32 facilities declined, 11 did not respond, and two accepted, and one is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014666	A. BUILDING: _____ B. WING _____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD ST CHARLES, IL 60174

(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 page 12	S9999		

interested. We have to see if [R1] will qualify to go to these facilities due to his dialysis needs."

On August 19, 2024 at 1:38 PM, V8 (Homeless Shelter Case Manager) said, "I manage the homeless male residents at the shelter. No one from the facility ever called me and talked to me about placing [R1]. We have a procedure for taking people. They have to send us paperwork, including discharging paperwork. They have to make contact with someone here in order to send a person. We explain the shelter and let them know they have to be self-sufficient to be here. I watched him, and he could not transfer himself from the [ride share vehicle] to the wheelchair. The paramedics had to help him. I saw that happen. We did not know he was coming that day. It was almost 4:30 PM, and our guest coordinator told us someone was being dropped off and we needed to go downstairs immediately. [R1] wasn't even aware where he was sent to. We do not accept residents from the county [R1] was coming from."

On August 20, 2024 at 9:28 AM, V7 (Homeless Shelter Director of Programs) said, "It is not uncommon for nursing homes or hospitals to do a patient dump, but we have a procedure for when a resident is going to be sent to us, to get prior authorization. That did not happen with [R1]. On August 14, 2024 around 4:00 to 4:15 PM, a van pulled up in our parking lot and [R1] was getting out and we addressed him, and he said he was involuntarily discharged from [the facility]. I immediately got on the phone and talked to [V3] (SSD), and she said she did not do the discharge that it came from Administration. She said he was a danger to others. I said they just dropped off someone who cannot qualify for services in our county. I told her we are not a medical

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	IL6014666	A. BUILDING: _____ B. WING _____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD ST CHARLES, IL 60174

(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 page 13	S9999		

facility. I asked him to go the hospital and have them contact the physician. No one from the facility reached out to us. There was no authorization for him to come here. Not even a call to ask if we could accommodate him. We would not have accepted him. We would not have been able to take care of him. We are a temporary solution; we are not long-term housing. He needs dialysis, he needs to take medications, we don't do that here."

On August 21, 2024 at 11:44 AM, V7 (Homeless Shelter Director of Programs) said, "The sleeping arrangements at the shelter are on a first come, first served basis. The sleeping quarters are open from 6:00 PM to 7:00 AM, seven days a week. Everyone in the sleeping quarters is given a wake-up notice between 6:15 AM and 6:30 AM, and everyone has to be out, with all of their belongings at 7:00 AM when the doors are locked until the evening. People can get three meals a day in our cafeteria, but the cafeteria closes between meals. We do not pack meals for people leaving to go to a job or to dialysis. We would not have been able to provide [R1] with meals to take with to dialysis. We have a drop-in center that is open from 8:00 AM to 11:45 AM and 1:00 PM to 4:45 PM where people with no place to go can hang out. During the period of April 1 to October 1, the drop in shelter is closed on Saturdays and Sundays, and homeless people have to find their own shelter during the day, so for instance [R1] would have had to find somewhere to go during the day on Saturdays and Sundays until October 1. If he had to have dialysis on Saturdays, he would have to arrange and pay for his own transportation, and they would have to pick him up somewhere else since our shelter is closed in the summer. He also would have had to carry all of his belongings with

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S9999	Continued From page 14	S9999		

him everywhere he went because we do not store any belongings here."

The facility's Discharge Planning policy dated June 24, 2024 shows: "It is the policy of the facility to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions, in accordance with State and Federal Regulations. Procedure: 1. The facility's discharge planning process will be consistent with the discharge rights set forth at 483.15(b) as applicable. ...6. The facility will involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan ..."

The facility's policy entitled Involuntary Discharge (IVD), dated June 19, 2020, and reviewed January 28, 2024 shows: "To provide proper notification to all parties regarding a resident who is being involuntarily discharged. Guideline: 1. The facility will provide notification of an involuntary discharge or transfer according to guidelines established by Federal and State agencies. 2. An involuntary discharge will be issued under the following circumstances: a. An appropriate alternative placement is located, b. The transfer or discharge is necessary for the resident's welfare, c. The discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility, d. The facility discharges a resident because the health of other individuals in the facility would otherwise be endangered, e. The facility discharges a resident

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S9999	Continued From page 15 because of late or non-payment for services. 3. The resident responsible party (if appropriate) and agencies are notified in writing of the discharge 30 days prior to the discharge date. This is done via a notice of Involuntary Discharge form with an opportunity for hearing. 4. A copy of this notice must also be sent to the Department of Public Health and the local Ombudsman's office, if the resident is receiving Medicare, the Department of Public Aid. 5. The request for hearing form delivered to the resident. 6. Document in the resident record that the discharge and procedure were discussed with the resident and/or their representative if appropriate. 7. The resident cannot be involuntarily discharged from the facility until the process is completed." "A"	S9999		