Illinois Department of Public Health

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 03/27/2024

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

(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 2491479/IL170090	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1220 b)3) 300.3210 t) 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		

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S9999	Continued From page 1 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. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to protect a resident from physically abused by another resident; and failed to have abuse risk assessments, including plans of care and interventions in place for R1 and R2. These failures applied to two (R1, R2) of four residents reviewed for abuse, and resulted in R1 sustaining a right arm fracture after being found being pulled by R2 across room floor. Findings include:	S9999		

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Facility Reported Incident of 02/13/2024 10:15 PM reds in part, "(V20, Certified Nursing Assistant) was walking passed R1's room while completing rounds and saw (R1) on the ground. (R1) complained of pain to the right shoulder and right arm. (R2) was noted in (R1's) room holding onto (R1's) arm. (R2) stated that she thought (R1) was in her room."

1. R1 is an 88 year old female admitted to the facility on 12/22/2023, with diagnoses including but not limited to Dementia; Unspecified Hearing Loss; Hypothyroidism; and Encounter for Palliative Care.

R1's MDS (Minimum Data Set) assessment, dated 12/22/2023 under section C, documented R1 displays problems with Short and Long Term Memory, and R1's Cognitive Skills for Daily Decision Making are moderately impaired.

R1's MDS (Minimum Data Set) assessment, dated 12/22/2023 under section GG, documented R1 completes Rolling left and right and Lying to sitting on side of bed with Partial/moderate assistance.

R1's Fall Assessment, dated 01/02/2024, shows R1 is at high risk for falls.

R1's Abuse care plan, dated 02/14/2024 was developed and implemented the day after incident of 02/13/2024, and there was no Abuse care plans provided during the course of this survey that were created/implemented in order to address risk of abuse or interventions for R1 prior to incident of 02/13/2024.

Progress note, dated 02/13/2024 at 10:15 PM written by V15 (Licensed Practical Nurse), reads,

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"It was reported to this writer, (R1) was observed on the floor in the side lying position in bedroom near doorway. (R1) accompanied by peer, peer noted to be holding (R1) left arm at the time of occurrence. (R1) assessed for any apparent injuries, AROM/PROM (active range of motion/passive range of motion) performed on extremities x4. (R1) c/o (complained of) pain to Right Shoulder and Right Arm. (R1) is alert & oriented x2, with confusion. Bruise noted on Left Forearm. (R1) offered PRN pain medication, (R1) refused. (R1) denies hitting head. Writer contacted EMS (Emergency Medical Services) to transfer the resident to (local) Hospital for evaluation. ADON (Assistant Director of Nursing)/ADMINISTRATOR/ DON (Director of Nursing) made aware of transfer. Writer attempted to contact (family), no answer at this time."

Hospital record, dated 02/14/2024, reads, "(R1) presents with fall. (R1) on (anticoagulant) and it her head. Physical exam: Extremities: right shoulder tender with limited ROM (Range of Motion). X-Ray right shoulder: Acute impacted humeral neck/proximal humeral fracture."

2. R2 is a 90 year old female admitted to the facility on 01/05/2024, with diagnoses including but not limited to Dementia; Adjustment Disorder with Mixed Disturbance of Emotions and Conduct; Insomnia; Major Depressive Disorder; and Hypertension.

R1's MDS (Minimum Data Set) assessment, dated 01/12/2023 under section C, documented R2 has BIMS (Brief Interview of Mental Status) score of 8, indicating moderately impaired cognition.

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Progress note, dated 11/22/2023 at 12:13 PM written by V23 (Registered Nurse), reads, "It was reported to this writer by the witnesses that (R2) was getting out of her room and another resident questioning that "this is my room" - (R2) approached the other resident angry trying to run her over with her wheelchair and quickly hit the other resident on the top of other resident's head."

R2's care plan, dated 01/05/2024, reads, "(R2) presents with short and long term cognitive deficits, hx (history) of Dementia with aggression."

Progress note, dated 01/09/2024 at 1:29 PM written by V22 (Advanced Practical Nurse), reads, "(R2) has frequent behavioral disturbances at last facility."

R2's Wandering and Behaviors care plan, dated 02/14/2024 was developed and implemented the day after incident of 02/13/2024, and there was no Wandering and Behavior care plans shown that were created/implemented in order to monitor R2 prior to incident of 02/13/2024.

Progress note, dated 02/19/2024 at 1:59 PM written by V13 (Primary Care Provider Advanced Practical Nurse), reads, "(Nurse) reports that (R2) is very agitated at night and noted aggressive with other patients and difficult to redirect."

R2's physician order sheet, dated 02/19/2024, reads, "Trazodone HCL tablet 50 MG Give 1 tablet by mouth at bedtime for depression and anxiety."

Progress note, dated 02/26/2024 at 9:35 AM written by V14 (Psychiatric-Mental Health Nurse

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Practitioner), reads, "Notified by nurse last weeks that (R2) with aggressive behaviors noted, order given to add (psychotropic medication)."

On 03/21/2024 at 1:52 PM, Surveyor attempted to interview R1. R1 did not respond to questions. R1 observed sitting up in the bed with her eyes closed. R1 noticed to look frail and vulnerable.

On 03/25/2024 at 11:15 AM, Surveyor observed R2 laying on the bed in a random room. According to facility's census, dated 03/21/2024, R2's room was listed to be two rooms down from where surveyor found her. R2 stated, "I don't remember pulling any resident out of their bed."

On 03/25/2024 at 11:19 AM, V11 (Agency Registered Nurse) stated in summary: R2 is sleeping in an empty room right now. It is not currently occupied, but she resides in another room.

On 03/25/2024 at 11:22 AM, V10 (Certified Nursing Assistant) stated in summary: R2 is confused. She goes back and forth to different rooms. When R2 wanders around the unit, we redirect her. I wasn't here during the incident involving R1 and R2 on 02/13/2024, but I heard R2 pulled R1 out of bed. Maybe R2 thought it was her bed.

On 03/25/2024 at 2:00 PM, V13 (Primary Care Provider Advanced Practical Nurse) stated in summary: I follow up medical conditions and only know of any resident behaviors from nurses' report. On 02/19/2024, I was notified that R2 was agitated and aggressive. My assessment from 02/19/2024 was done in connection to the incident involving R2 and R1 on 02/13/2023. I just

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overheard that R2 pulled R1 out of bed, but not sure about circumstances of the incident. Around the same time, psychiatry saw R2 and started her on new psychotropic medication. R2 has extensive psychiatric history but none of her medical condition would aggravate her behavior.

On 03/25/2024 at 2:08 PM, V14 (Psychiatric-Mental Health Nurse Practitioner) stated in summary: I only saw R2 couple of times. On 02/19/2024, I was notified that R2 was having agitation and behaviors. I prescribed a new psychotropic medication at the time, and I followed up on 02/26/2024, R2 was calm and had no behaviors. R2 was not followed by psychiatry before 02/19/2024; therefore, I don't know if R2 had any behaviors before then.

On 03/25/2024 at 3:30 PM, V1 (Administrator/Abuse Coordinator) stated in summary: Since 01/05/2024, the day of R2's admission, R2 was involved in only one incident that occurred on 02/13/2024. That's when R2 was found in R1's room. I got a call from V15 (Licensed Practical Nurse/LPN), that R2 was found in R1's room, holding and pulling R1's left arm. Because R1 was found on the floor and has history of falls, we concluded, it was an unwitnessed fall. I did the investigation and interviewed directly involved staff. There were no residents present in the hallway at the time of the incident. The following morning, I spoke to most interviewable residents on the unit and they denied hearing any incident or loud noises form the night before. Based on lack of aggressive behaviors during R2's stay in the facility, it was concluded, R2 was trying to help resident get up from the floor.

On 03/26/2024 at 11:18 AM, V9 (Social Worker)

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stated in summary: A vulnerable resident is someone who has dementia or is unable to communicate clearly. I create and initiate abuse care plans on as needed basis. I develop abuse care plans for residents who experienced previous trauma or abuse. Demented residents are not necessarily at risk for abuse even though they are vulnerable.

On 03/26/2024 at 11:45 AM, V20 (Certified Nursing Assistant) stated in summary: I was making rounds on the evening of 02/13/2024, and saw R2 in R1's room. R1 was already on the floor and R2 was holding and pulling R1's arm. Both of them were right by R1's bed, and R2 was pulling R1 away from the bed, towards the doorway. R2 kept saying, "Get out of my room" repetitively. I called V19 (LPN), we redirected R2, and she was escorted back to her room. Sometimes R2 is hard to redirect due to her confusion, she wanders into other residents' rooms. R2 was monitored as per protocol, every two hours, on daily basis. On the day of the incident, I saw R2 right after dinner, around 8:00 PM, and then, at the time of the incident that occurred around 10:30 PM.

On 03/26/2024 at 1:43 PM, V15 (Licensed Practical Nurse) stated in summary: I was on my lunch break during the incident involving R1 and R2. R1 was my patient that night (02/13/2024). When I return back to the facility from the lunch break, V19 (LPN) informed me that V20 (CNA) noticed R1 was on the floor and R2 was in the room holding on to R1's arm. They were both confused. That was the report I received. I assessed R1. R1 complained of pain, so I notified the doctor and received an order to send R1 out to the hospital, where R1 was diagnosed with right arm fracture. I spoke to both R1 and R2

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after the incident. R2 was in a very confused state, but she was able to communicate that she wandered in to R1's room. It was her typical behavior, R2 wandered into other residents' rooms. R1 didn't really give a description of what happened, she just complained about right arm pain. We kept R2 under direct supervision, checked on her every 15 minutes after the incident. R2 was normally encouraged to stay in the dining room or ambulate in the hallways to stay visible to staff, but we monitored her as any other resident, every two hours. Sometimes R2 gets aggressive with staff when redirected.

On 03/26/2024 at 3:10 PM, V19 (Licensed Practical Nurse) stated in summary: I was in the nursing station when V20 (CNA) called me into R1's room. When I came in, R2 was holding on to R1's arm and they both kept saying, "This is my room." R2 was trying to pull R1 out of the room. We had to redirect R2 and she was escorted to her room. Prior to the incident, R2 was asleep in her room. R2 must have gone unnoticed into R1's room and tried to pull R1 out of there. I worked with R2 before, R2 needed to be redirected while wandering around the unit.

The facility "Abuse Prevention" policy (no date) reads, "The purpose of this policy and the Abuse Prevention Program is to describe the process for identification, assessment, and protection of residents from abuse, neglect, misappropriation of property, and exploitation. This will be accomplished by: establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; identifying occurrences and patterns of potential mistreatment; implementing systems to promptly and aggressively investigate all reports and

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S9999	Continued From page 9 allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Serious Bodily Harm is defined as an injury involving extreme physical pain, substantial risk of death, protracted loss, or impairment of the function of a body member, organ, or mental faculty, or requiring medical intervention such as surgery, hospitalization, or physical rehabilitation." (A)	S9999		