STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF MONTCLARE, THE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(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 Complaints Investigation 165336/2388434	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 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. 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 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 interviews and records review, the facility failed to ensure resident safety for one resident (R2) of three residents reviewed. This failure resulted in R2 falling and sustained right leg laceration. R2 was taken to the emergency room and received sutures on the right leg. R2 is not currently in the facility. Findings include: According to current POS (Physician Order Sheet), R2 is an 83-year-old individual admitted to the facility on 10/28/21. R2's medical diagnosis includes but not limited to: Acute on chronic diastolic (congestive) heart failure, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R2's Brief Interview for	S9999		

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S9999	Continued From page 2 Mental Status (BIMS dated 8/4/2023 document R2's BIMS as 2/15, indicating R2's has severe cognitive impairment. R2's functional status dated 8/4/2023 documents R2 is dependent for toileting hygiene, Shower/bathe self, Lower body dressing, lying to sitting on side of bed, Chair/bed-to-chair transfer. Facility's MDS (Minimum Data Set) section GG (functional Abilities) defines Dependent as: -Dependent - Helper does ALL the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. On 11/14/2023 at 3:08PM, V2 (Director of Nursing-DON) said on 10/02/2023 about 12:00am, V15 (Certified Nursing Assistant-CNA) told V2 that R2 was in bed sleeping. V15 woke R2 up and told R2 V15 needed to change R2 because R2 had a bowel movement. V15 said R2 said OK, and when V15 attempted to change her, R2 started becoming restless. V15 said when R2 became restless, V15 stopped what she was doing and explained to R2 what V15 was doing but R2 remained restless. R2 then tried to slip out of bed so V15 tried to support R2's weight and lowered R2 to the floor. V2 said V16 (RN) entered the room at that time, and that is when V15 and V16 noticed blood coming out of R2's right lower leg. V2 said V16 applied pressured and called the physician because the pressure was not reliving the bleeding on R2's leg. V2 said the physician gave orders to V16 to call 911 and transport R2 to emergency room of the community hospital. V2 said after R2's fall and injury to the right lower leg, V15 was assessed and educated on bed mobility to determine what education V15 needed regarding bed mobility to prevent falls. V2 said	S9999		

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S9999	Continued From page 3 V15 should have called someone else to assist her if R2 continued to be restless since V15 was having a hard time calming R2. V2 said R2 is a two person assist for transfer with mechanical lift when getting out of bed. V2 said V2 followed up with the community hospital and was informed R2 was admitted to the hospital with diagnosis injury to the right lower extremity and sutures were applied on right lower extremity. V2 said when V2 got the report from the hospital, V2 was not told how many sutures R2 received on her right leg. On 11/15/2023 at 3:15pm, V15 (Certified Nursing Assistant-CNA) said she went to R2's room to check on R2 to see if she was ok at about 11:00pm. R2 was wet with urine and had a bowel movement. V15 said she informed R2 she was going to change R2 and R2 consented. V15 said she was trying to clean R2 when R2 started yelling and screaming. V15 explained to R2 what V15 was doing. R2 calmed down but as soon as V15 started cleaning R2 again, R2 got agitated and tried to get out of bed. V15 said R2 cannot control her legs and started sliding out of bed so V15 tried to ease her to the floor while protecting her head. V15 yelled for help and V16 (Registered Nurse-RN) came to help but by the time the V16 came blood was observed on the floor. R2's right leg was observed with a cut on the side. V15 said she thought R2's leg got caught on the lower part of the bed as R2 was sliding down but V15 was not sure how the cut happened. V15 said she was not within reach of the call light when R2 fell. On 11/15/2023 at 3:33pm, V16 (Registered Nurse) said she was the Nurse for R2 when R2 fell. V16 said V15 (CNA) yelled for help, and when V16 went to R2's room, she found R2 on the floor one leg was bleeding. V16 said the	S9999		

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S9999	Continued From page 4 length of the laceration was about 1.5cm. V16 applied pressure dressing but the laceration continued bleeding, therefore V16 called the physician who gave orders to call 911 and sent to R2 to the ER (Emergency Room). V16 said R2 was a high fall risk patient. V16 said R2 was restless and agitated and was moving around during care. V15 was unable to control R2 because R2's legs are very heavy, therefore V15 protected R2's head and the legs were caught on the bed frame which caused laceration to R2's leg. V16 said usually R2 was calm during care and had never shown signs of agitation. V16 said, the day R2 fell and got injured, R2 was sleeping when V15 was changing R2. This woke R2 up and it caused R2 to be agitated and restless. V16 said the staff should wake the resident up before changing them to make sure they know what is happening. V16 said R2 moved her legs from side to side and her legs are very heavy and that is why R2 slide off the bed, causing the R2 to fall. V16 said R2 was usually a very calm and cooperative resident and was alert and could understand what she was being told to do. V16 said she did not know what happened that day to cause R2 to be agitated as R2 had never behaved like this before. On 11/16/2023 at 11:04am, V18 (Physical Therapy-PT) said V18 evaluates residents when they are admitted for physical therapy to assess for bed mobility, functional transfer, ability to ambulate or walk and stair usage. V18 said R2 was not on PT schedule at the time of the fall. V18 said R2 had knee contractures and R2 was discharged from therapy because of no progress in terms of transfer. V18 said R2 was recommended by physical therapy to use a mechanical lift for transfers. V18 said R2 was able to roll on each side with standby assistance	S9999		

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S9999	Continued From page 5 for cuing and for safety. V18 said R2 was not able to sit up or pull herself up. R2 needed two people to scoot R2 up, sit her at the end of the bed or to reposition R2 because R2 was heavy. V18 said it would be very difficult for R2 to scoot herself up and down the bed or swing her legs out of the bed because of her lower body weakness. Facility policy titled Fall Prevention and Management, dated 10/29/2021, revised 10/30/2023 documents: -Facility is committed to its duty of care to residents and patients in reducing risk, the number and consequences of falls including those resulting in harm and ensuring that a safe patient environment is maintained. Nursing progress notes dated 10/2/2023 document: Staff (V15-Certified Nursing Assistant -CNA) called for help. Resident's (R2) room lying on the floor head up lying on her back. Right lower leg laceration noted. MD notified new order call 911 sent to ER (Emergency Room). Facility Reported Accident Report (FRI) dated 10/03/2023 documents: -On 10/03/2023 facility got call from hospital ER (Emergency Room) and was informed R2's admitting diagnosis of laceration of lower extremity with sutures for observations. (B)	S9999		