		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6012686	B. WING			C <b>26/2024</b>	
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE			
PEARL C	PEARL OF ELK GROVE, THE  1920 NERGE ROAD  ELK GROVE VILLAGE, IL 60007						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
S 000	Initial Comments		S 000				
	Complaint Survey:	2472289/IL171123					
S9999	Final Observations		S9999				
	Statement of Licens	sure Violations					
	300.610a) 300.1210b) 300.3240a)						
	Section 300.610 R	esident Care Policies					
	procedures governifacility. The written be formulated by a Committee consisti administrator, the a medical advisory conformed and othe policies shall complicate the facility and shall shall be facility and shall facility.	dvisory physician or the ommittee, and representatives r services in the facility. The ly with the Act and this Part. shall be followed in operating I be reviewed at least annually documented by written, signed					
	Section 300.1210 ( Nursing and Persor	General Requirements for nal Care					
	and services to atta practicable physica well-being of the re- each resident's con plan. Adequate and care and personal of resident to meet the care needs of the re-	provide the necessary care ain or maintain the highest I, mental, and psychological sident, in accordance with apprehensive resident care I properly supervised nursing care shall be provided to each total nursing and personal esident.					
	tment of Public Health / DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE **Electronically Signed** 03/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			1	С		
		IL6012686	B. WING		03/2	6/2024
NAME OF PROVIDER OR SUPPLIER STREET AD			DRESS, CITY, S	STATE, ZIP CODE		
PEARL (	OF ELK GROVE, THE		GE ROAD	: 11 60007		
0(4) ID	CHIMMA DV CTA		VE VILLAGE	PROVIDER'S PLAN OF CORRECTION	DNI .	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 1	S9999			
	Section 300.3240 /	Abuse and Neglect				
	a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)					
	These Requiremen evidenced by:	ts were NOT MET as				
	review the facility fa free from physical a left pinky finger bein care and x-ray show of the left finger. The	on, interview, and record illed to ensure a resident was abuse. This resulted in R1's ng pulled backwards during wed a non-displaced fracture ils applies to 1 of 3 residents buse in the sample of				
	The findings include	ə:				
	female with diagnost osteoarthritis, macu	ows she is a 67-year-old ses including type 2 diabetes, ılar degeneration, atrial displaced fracture of distal finger.				
	show she is cognitive rejections of care, or	a Set assessment dated 2/1/24 vely intact, has no behaviors, or delusions. She requires sist with showers/bathing.				
	documents R1 verb March 16, 2024, tha	Report dated 3/19/24 palized today, on Saturday at CNA (Certified Nursing her a shower and was not				
	states, "On Saturda	ed 3/19/24 documented by V3 by 3/16/24 PM shift, I was y shower. V6 was my CNA.				

Illinois Department of Public Health

STATE FORM 3D0G11 If continuation sheet 2 of 5

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	TIPLE CONSTRUCTION ING:		(X3) DATE SURVEY COMPLETED	
		IL6012686	B. WING		03/2	26/2024	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE			
PEARL OF ELK GROVE, THE 1920 NERGE ROAD							
	T		VE VILLAGE,				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 2	S9999				
	She was not very ni shower chair as sor She washed me wit She did not do a go grabbed my left arm shower chair. She e while she was gettir pinky finger was be R1's Diagnostic Imashows a transverse base of the distal plot On 3/25/24 at 9:05 room sitting in her wifinger was wrapped with elastic bandage 8:00 PM, V6 (Agencyou a shower. She room. I asked her if chair because it was before me. She said her again if she coushe told me "I alreathen grabbed me by transferred me to the washcloth on the gron the floor. She pic want to use them the listen to my request She washed my fact washing my body. from her, and she gpulled it backwards hurt me. V6 was a result of the solution of the ground in the graph of the graph	ice, refused to clean the mebody used it before me. It towel that was on the floor. It towel that was on the floor. It was transferred to a even hurt my left pinky fingering the towel I was holding. My int backward"  aging Results dated 3/20/24 in non-displaced fracture at the halanx of the left little finger.  AM, R1 was observed in her wheelchair. Her left pinky					
	R1's nurse on 3/19/ of pain to her left pi	AM, V4 (RN) said he was 24 when she was complaining nky finger. Her left pinky finger n. I asked if anything					

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STATE FORM 3D0G11 If continuation sheet 3 of 5

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IL6012686	B. WING			C <b>26/2024</b>
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE	-	
PEARL (	PEARL OF ELK GROVE, THE 1920 NER ELK GRO			IL 60007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 3	S9999			
	a shower from V6( <i>F</i> got pulled. R1 is ale it was done intentio me.	me on 3/16/24 she received Agency CNA), and her pinky ert and oriented, I asked her if nal and she did not answer PM, V9 (Social Services) said				
	I was asked to chec doing after an incide she was receiving a sounded like it was Something about th washcloth. R1 was does not want agen	ck on R1 to see how she was ent with V6 (CNA). R1 told me a shower from V6, and it not a good experience. Leir being a tussle with the visibly upset and said she acy staff to care for her. R1 complaints about staff in the				
	3/16/24, R1 approa shower. R1 told me gave her a shower. washcloth being dro used the dirty wash R1's nurse that day R1 was not happy v	PM, V5 (LPN) said on ched me after V6 gave her a she did not like the way V6 She complained about the apped on the floor and she cloth to clean her. I was not , I reported to her nurse that with the shower and that V6 e of her anymore. Both the agency staff.				
	she was notified on of pain to her pinky body hurt you, and nice to her during a about her finger, sh backward. V6 was t	PM, V3 (RN Supervisor) said 3/19/24, R1 was complaining finger. I asked her did any she said a CNA (V6) was not shower. When I asked her e told me it was bent crying to get the towel from her sustained a fracture to her y some trauma.				
		PM, V1 (Administrator) said DNR (Do Not Return) list for				

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STATE FORM 3D0G11 If continuation sheet 4 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	<del></del>		,
		IL6012686	B. WING		03/2	6/2024
NAME OF PROVIDER OR SUPPLIER STREET AD			DRESS, CITY, S	STATE, ZIP CODE		
PEARL (	OF ELK GROVE, THE	1920 NER		- 11 00007		
040.15	CLIMMA DV CTA		VE VILLAGE		TON	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 4	S9999			
	this facility. V1 confirmed R1 sustained a finger fracture, and R1 will be following up with the orthopedic physician.					
	(DON) per R1 durir 3/16/24, while CNA	ated 3/19/24 documents by V2 ng shower on Saturday (V6) was providing care and she reported her finger was				
	returned back from	ated 3/20/24 documents (R1) a physician appointment. Left eft hand digit fracture. R1 has nd pain 3 out 10.				
	shows my compreh factor that may incr abuse/neglect. I de neglect or mistreatr	lan dated through May 2024 tensive assessment reveals ease my susceptibility to my any history of abuse or ment and no indicators of past strator of mistreatmentI am rable adult.				
	"Residents have the neglect, exploitation or mistreatment. The corporal punishment any physical or che willful infliction of in definition of abuse, have acted deliberation."	ed Abuse Policy states, e right to be free from abuse, n, misappropriation of property his includes but is not limited to nt, involuntary seclusion, and mical restraint Abuse is the jury willful, as used in this means the individual must ately physical abuse if the n a resident that occurs other means"				
	(B)					

Illinois Department of Public Health STATE FORM

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