STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058065	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF EVANSTON,THE	820 FOSTER STREET , EVANSTON, Illinois, 60201

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S0000	Initial Comments Annual Licensure Health Survey	S0000		
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	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 personal care needs of the resident. 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 record review the facility failed to supervise a resident at high risk for falls with history of falls; failed to train nursing staff to recognize resident's physical ability and level of assistance; and failed to implement measures to prevent a fall for 1 of 2 (R17) residents reviewed for falls in the sample of 55. These failures resulted in R17 being emergently transferred to the hospital and admitted with left hip fracture that required surgical intervention. Findings include: R17 is a 90-year-old female admitted to the facility on 12/06/2023 with diagnosis including but not limited to Type 2 Diabetes Mellitus with Diabetic Neuropathy; Heart Failure; Restless Legs Syndrome; Generalized Anxiety Disorder; Major Depressive Disorder; Reduced Mobility Difficulty in Walking; Lack of Coordination; Unspecified Fall; Repeated Falls. According to R17's MDS (Minimum Data Set) assessment dated 03/17/2025 under section C, R17 has BIMS (Brief Interview of Mental Status) score of 7 indicating severe cognitive impairment.	S9999		

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S9999	Continued from page 2 According to R17's MDS (Minimum Data Set) assessment dated 03/17/2025 under section GG, shows that R17 requires supervision or touching assistance to walk 10 feet, refused to be assisted to walk 50 feet, and requires partial/moderate assistance in toileting hygiene. R17's fall history shows R17 fell on 05/10/2024, 02/04/2025, 03/18/2025, and 03/27/2025. R17's fall risk assessment dated 02/04/2025 shows R17 scored 18 indicating high risk for falls. R17's fall care plan initiated 12/10/2023 reads in part, "(R17) has potential for falls, functional deficits, history of falls, muscle weakness, admitted with a diagnosis of non-displaced rib fracture right 4th-7th ribs and left 5th, and 6ht ribs s/p fall, has RLS. Interventions: Anticipate and meet resident needs; Assist resident to get up and out of bed during the night; Check on resident frequently and place resident in visible view of staff when up in chair as resident will allow; Encourage and assist as needed to wear non-slip footwear; Get to know residents habits to anticipate resident's needs; Provide adequate lighting." R17's ADLs care plan initiated 09/10/2024 reads in part, "(R17) has an ADL Self Care Performance Deficit r/t Decreased motivation, fall risk, Lack of motivation, Pain, Refusal to complete ADL tasks, weakness/deconditioning. Interventions: TOILET USE: Provide total assistance; TRANSFER: The resident requires total assist (Hoyer lift) with transfer (Date Initiated: 03/11/2025)". On 05/12/25 at 12:46 PM R17 sitting in the reclined specialty chair by the room. R17 not interviewable. On 05/13/25 at 01:26 PM V8 (Family Member) said, "I visit R17 all the time, I live only few minutes away from the facility. Before R17's fall (on 03/18/2025), R17 was pretty stable with walking with the walker. R17 would always go to the bathroom by herself. I don't know if she should have gone by herself, but she did. At the time of the fall, R17 was residing on the third-floor unit. R17's room was all the way at the end of the hallway, far from the enclosed nursing station."	S9999		

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S9999	Continued from page 3 V8 started to cry and said, "They ruined mine and her life by not preventing the fall, she's not the same anymore. That day (03/18/2025), I brought in food for R17 and left around 09:30 PM - 10:00 PM. I woke up the following morning and noticed missed call form the facility. V16 (Registered Nurse) said in the voicemail that R17 initiated emergency call light in the bathroom but by the time staff went into R17's room, she already attempted to go back to the bed, and fell in the middle of the room. That made me wonder how long she waited in the bathroom before she decided to attempt to go back to the bed. R17 was sent out to the hospital, had broken the hip, followed by surgery, and came back after 10 days. I tried asking her what happened but R17 doesn't remember. R17 is so different now. R17 only needed minimal assistance before the fall, and now she cannot even sit up in the chair and doesn't really talk either whereas before we talked all the time. R17's condition declined tremendously." On 05/14/25 at 09:29 AM V10 (Certified Nurse Assistant) said, "I worked on 3/17/2025 11:00 PM to 7:00 AM. Around 1:15 AM, R17's call light went off. I went to answer it and as I headed down to the room I heard her fall. R17 initiated the emergency bathroom call light. When emergency call light is initiated, it gives different sound, so I recognized it and started walking fast but didn't make it to R17's room before she got off the toilet. When I walked into the room, I saw R17 sitting on the floor with the walker in the front of her. I notified V16 (RN) right away, and he came in to assessed R17. I don't think R17 speaks English, but V16 (RN) asked her if she was in any pain and checked for injuries but there was no injury. We used the sit-to-stand lift to put R17 back in the bed and both, me, V9 (Certified Nurse Assistant), and V16 (RN) waited for an ambulance. I was not assigned to R17 that night, V9 (CNA) was. Everybody was checking on R17 frequently because she is not compliant and goes to the bathroom by herself." Surveyor asked what level of assistance R17 needs when going to the bathroom and what is her cognitive condition, V10 (CNA) said, "R17 was supposed to be assisted to go the bathroom. I don't know how her cognitive ability was because she doesn't speak English. When I took care of R17, I used hand gestures. I think the facility uses translators, but I only work night shift, so I don't think they have one who speaks her language at night. R17 was not a high risk fall resident before the fall (03/18/2025) to my knowledge. We just had to watch her when she went to the bathroom. There were no special interventions for R17."	S9999		

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S9999	Continued from page 4 V16 (Registered Nurse) not available per V2 (Director of Nursing). Per facility investigation report, V16 (Registered Nurse) who was the nurse caring for R17 at the time of the fall (03/18/2025), stated that he was called by V10 (CNA) to be notified that R17 was found on the floor in her room. V16 (RN) stated that he went immediately to R17's room and saw R17's walker and shoes next to the R17. V16 (RN) assessed R17 and concluded there were no injuries; however, R17 complained of the left leg pain. On 05/14/25 at 12:18 PM V2 (Director of Nursing) /Fall Coordinator) said, "R17 was admitted on 12/6/2023, she came into the facility for post fall rehab. R17 walked independently 50 feet with the walker, prior to the fall (03/18/2025). R17 always wants to do everything on her own. On 03/18/2025 she had unwitnessed fall. R17 went to the bathroom by herself and pulled the call light. V10 (Certified Nurse Assistant) headed to the room and found R17 on the floor. V16 (RN) came in immediately and assessed R17. R17 pointed to the pain in the abdomen and a little later in the left leg. R17 was send to the hospital. She suffered left hip fracture and had subsequent surgery. R17 has diagnosis of hypertensive urgency that can cause weakness, dizziness, and syncope. It is hard to determine if R17's blood pressure was elevated right before the fall, so it could have been a contributing factor to R17's fall but it is hard to determine. Some other contributing factors were lack of light in the room and inappropriate footwear, R17 wore sandals. R17 was not able to verbalize what happened. Nursing staff does "Purposeful Rounding" to anticipate residents' needs. We know R17 likes to do things on her own, so the best way to prevent her from falling would be purposeful rounding. Need anticipation is recognized by purposeful rounding even though she doesn't speak English and her cognition is severely impaired. We determined that the root cause of R17's fall was poor safety awareness, no call for assistance, hypertensive urgency, lack of lighting in the room, and inappropriate footwear." On 05/14/25 at 12:42 PM V9 (Certified Nurse Assistant) said, "I worked on 03/17/2025 11:00 PM - 7:00 AM. On 03/18/2025 between 1:00 AM - 2:00 AM, R17 pulled the call light. I was in the nursing station, and as I heard the call light, I headed out to R17's room which was the last room on the hallway. By the time I got to R17's room, V10 (CNA) was already there. V10 (CNA) told me that she found her on the floor. R17 was assigned to me that night. R17 was always independent and did everything for herself. R17 needed only supervision,	S9999		

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S9999	Continued from page 5 such as hand her a brief, etc. Normally, we round on assigned residents every hour on the night shift. The last time I saw R17, was around 1:00 AM. I'm not sure what happened. I don't know about any prior falls R17 might have had. She was never at risk for falls before 3/18/2025. There were no special interventions to prevent R17 from falling. I don't know what "Purposeful Rounding" is, I haven't heard of it." Surveyor asked how she anticipates R17's needs when R17's cognition is severely impaired and she doesn't speak English, V9 (CNA) said, "Normally, I would point to the item and R17 would nod her head. There is no other way to communicate with her, I don' know about any interpreting devices." On 05/14/2025 2:27 PM V15 (Nurse Practitioner) said, "I'm very familiar with R17. R17 is a loner, alert x2, very independent, and, before the fall, ambulatory. R17 took herself to the bathroom back and forth all the time. I was notified of R17's fall on 3/18/2025. I was told that R17 was using the bathroom and was later discovered on the floor. R17 was complaining of pain in the hip, so I placed an order to send R17 to the hospital. R17 has never fallen like that before. Best interventions to prevent falls is to do rounds and monitor when residents are in bed, also, to let me know right away after each fall. Staff should monitor residents every 4 hours especially at night, or however often the facility fall protocol is." V16's progress note dated 03/18/2025 reads in part, "(At) 2:10 AM Writer was notified by CNA who responded to (R17's) bathroom call light. (R17) was found by the CNA on the floor near her walker, a few feet from her bed. (R17) unable to describe events leading to the fall. HTT (head-to-toe) assessment done, claimed to have not hit her head on the floor, no observable bumps or bruises, complained of abdominal pain and was also holding her abdomen with facial grimace observed. BUE (bilateral upper extremities) and BLE (bilateral lower extremities) symmetrical in length, no internal or external rotation observed. Transferred to wheelchair, by 2 person assist and later to bed. Later observed to be having left leg pain but would not verbalize or confirm leg pain. V/S (vital signs) showed elevated BP 202/112. Other VS within normal limits. 2:40 (AM) (V15 (Nurse Practitioner notified and with orders to send patient to ER for further evaluation. Placed 911 Call. 2:50 (AM) (R17) brought to (local) ER. 2:55 (AM) Called (V8 Family Member), did not pick up. Left VM message. (R17) is ambulatory, able to toilet self and able to use the call button. Was last seen in her room 12:15	S9999		

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S9999	Continued from page 6 AM." Per hospital record, progress note written by V12 (ER Physician) dated 03/18/2025 reads in part, "(R17) is a 90 y.o. female with PMH of dementia, CHF, HTN, Hyperthyroidism, 4 cm AAA, and internal hemorrhoids, seen for medical co-management and risk stratification following unwitnessed fall c/b femur fracture. L intertrochanteric femur fracture; ground level fall at SNF, unwitnessed; found to have L intertrochanteric femur fracture on imaging; defer to surgical service for management periprocedural abx., analgesia, DVT ppx/AC; bowel regimen; and urinary symptoms." The facility "Fall Prevention and Management" policy dated 10/29/21 reads in part, "The 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. Procedures include Fall Risk Screening which include All residents and patients will be considered at risk for falling, regardless of fall risk score. High risk residents and patients for falls will receive individualized interventions as appropriate to risk factors. Fall Interventions include Universal Fall Precautions/Facility Fall Protocol will be implemented to all residents admitted to the facility regardless of risk scores. Fall Focus Program will be implemented to ensure purposeful rounding addresses residents positioning, pain, personal needs, personal items within reach, perils/safety hazards, and peaceful environment upon admission and throughout resident's stay." (A)	S9999		