STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145246	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Hinsdale, The	600 West Ogden Avenue Hinsdale, IL 60521

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36567 Based on observation, interview and record review, the facility failed to provide two person assistance during incontinence care and failed to implement a post fall intervention. This failure applies to 1 of 3 residents (R1) reviewed for falls in the sample of 3. This failure resulted in the resident falling off the bed and sustaining a left femur and a right shoulder fracture. The findings include: R1's EMR (electronic medical records) showed that R1 was sent to the ER (emergency room) on May 9, 2024 post fall and readmitted to the facility on [DATE] after hospital stay with diagnoses of unspecified fall, subsequent encounter, nondisplaced fracture of lateral condyle of right femur, subsequent encounter for closed fracture with routine healing, fracture of unspecified shoulder girdle, part unspecified, subsequent encounter for fracture with routine healing, unspecified injury of head, subsequent encounter. R1's diagnoses prior to discharge to the hospital included morbid (severe) obesity due to excess calories, other idiopathic peripheral autonomic neuropathy. Initial Consultation at ED (Emergency Department) on May 9, 2024 included the following information: R1 is a [AGE] year old female presented to ED for further evaluation after mechanical fall out of bed at the nursing home. R1 is on Xarelto (blood thinner) and primarily complained of headache where she hit her head, right shoulder pain and left knee and hip pain. ED evaluation with X-ray to shoulder shows comminuted displaced right neck humeral fracture primarily involving the humeral neck which is displaced up to 1.7 cm (centimeters) and also involves the humeral head cortex and tuberosities, soft tissue edema present. CT (Computed Tomography) of left knee shows fracture of both medial and lateral distal femur essentially nondisplaced extending into the tibiofemoral articular surface as well as patellofemoral articular surface. Orthopedic surgery was consulted for further management. R1's quarterly MDS (minimum data set) dated March 5, 2024 showed that R1 was moderately impaired in cognition. The same MDS showed that R1 was dependent on staff for toileting hygiene. The MDS assessment showed that the term dependent included that helper does ALL of 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. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R1's Fall Risk assessment dated [DATE] showed that R1 was at high risk for fall with a score of 16. R1's EMR showed that R1 was 264.0 pounds on May 3, 2024. Facility Final Report of R1's fall incident dated May 9, 2024 to IDPH (Illinois Department of Public Health), included that during ADL (activities of daily living) care, R1 was repositioned on her left side and slid off bed. R1 complained of pain to right arm. Medical Doctor notified and R1 sent to ER via 911 for evaluation. R1 sustained injuries of right humeral fracture and left humeral fracture. The same report included that according to CNA (Certified Nursing Assistant) interview, she was on R1's right side and she assisted R1 to the middle of the bed so that she could clean her and change her linen and was unable to prevent R1 slipping off the edge of the bed. Nursing progress notes dated May 9, 2024 included that per investigation of above incident, there was only one person present during care. R1's care plan initiated December 23, 2020 included that R1 has ADL self care deficit related to obesity, muscle weakness which may lead to physical limitations low activity tolerance related to diagnoses of degenerative disease to left knee, and back, carpal tunnel, peripheral autonomic neuropathy. Intervention created and initiated on March 8, 2024 included for staff to provides extensive to total assist in bed mobility, transfer, toileting check and change . R1's care plan revised May 09, 2024 included that R1 had an actual fall related to poor balance. Interventions created and initiated on May 09, 2024 included to transfer to ER 911 for evaluation. Upon return bariatric bed will be provided and 2 staff will assist for ADLs. Interventions created and initiated on May 17, 2024 included : Protection /Safety Hazards/Peril: Staff will assess its physical environment, device, equipment, including furniture, appliances, beds, wheelchairs, etc. to ensure that it don't pose as a safety risk or hazard. On May 20, 2024 at 9:38 AM, R1 was seen lying in a regular sized bed and appeared morbidly obese and occupied the entire width of the bed and mattress with no extra space on either side. When asked if the bed/mattress size were adequate size for her, R1 remarked No, both are too small. R1 stated that she was in a similar sized bed when the fall incident occurred. Regarding the fall incident of May 9, 2024, R1 stated I fell when she (CNA) was changing me (providing incontinence care). She turned me towards the door (left side) to the edge of the bed and before you know it, I was on the floor. She was the only person changing me then. Now there are two. Happened after 5 (5:00 AM) in the morning. R1 stated that there were no side rails for her to hold on to while she was turned. R1 stated that she broke her right shoulder and left leg during the fall. R1 stated that the bedside table was there towards the left side during the fall. On May 20, 2024 at around 10:20 AM, facility was asked to provide measurements of R1's mattress and bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On May 20, 2024 at 12:17 PM, V1 (Administrator) stated that R1 was on a 42-inch bed during her fall incident and was placed in a 42-inch bed when she was readmitted over the weekend. V1 stated that a 48-inch bed is considered a 'bariatric' bed. On May 20, 2024 at 12:39 PM, V5 (Assistant Director of Nursing) stated that she did the root cause risk analysis post R1's fall and had intervention in R1's care plan that she (R1) would have a bariatric bed on readmission from hospital. V5 stated that a bariatric bed is 6 inch wider than R1's previous bed. On May 20, 2024 at 1:04 PM, V6 (Maintenance Director) stated that around 10:30 AM that morning, he was told to change R1's both bed and mattress from a 42 inch to 48 inch bed and mattress. V6 stated, that the 42-inch bed is extendable to a 48-inch bed. V6 stated that he was not notified earlier to do the same. On May 20, 2024 at 2:15 PM, V3 (CNA) stated that she works the night shift and has always assisted R1 with incontinence care by herself. V3 stated that on May 9, 2024 at around 6:00 AM, while providing incontinence care for R1, she was on the right ride of R1 and turned R1 on to her left side towards the middle of the bed. V3 stated that the sheet underneath R1 was wet so she proceeded to change the whole bed and pulled the sheet from underneath R1. V3 stated that just as she turned to get the clean linen, R1 rolled off the bed on the left side towards the bedside table. V3 stated that she was unable to prevent R1 from sliding off the bed. On May 20, 2024 at 10:28 AM, V4 (CNA) stated that she usually works the day shift and has taken care of R1 prior to her fall incident. V4 stated I used to do her incontinence care by myself. I always pull her towards me and turn her so that she has more room. On May 20, 2024 at 2:55 PM, V8 (MDS Coordinator) stated that toileting hygiene includes wiping the resident during incontinence care. V8 stated that R1 is not able to wipe herself. V8 stated that the term 'dependent' usually involves two or more staff. On May 20, 2024 at 3:11 PM, V9 (R1's Physician) stated that the facility should follow their protocol regarding assistance or provide bariatric bed depending on whatever difficulty the patient has in bed. Facility Policy titled Fall Prevention and Management (last revised April 8, 2024) included as follows: Policy Statement: 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: 2. Fall interventions: b) High Risk Precautions will be implemented to residents and patients whose scores on Resident Family/Notification screen shows high risk will be considered on this precaution. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	4. Fall Response: Investigate fall circumstances. Initiate Risk Management/Fall Event. 2.m. Safety hazards 5. Implement immediate intervention post fall at least within same shift.