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	10/24/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40054 Based on the observations, interviews, and record reviews, the facility failed to return the heart monitor devices to the cardiology monitoring departments per physician orders and label instructions. This applies to 2 of 3 (R2 and R3) residents reviewed for heart monitoring devices in a sample of 7. Findings include: 1. The EMR (Electronic Medical Record) showed R3 was a [AGE] year-old female with diagnoses including congestive heart failure, chronic pulmonary edema, pleural effusion, coronary artery diseases, atrial fibrillation, presence of coronary angioplasty implants and grafts, end-stage renal disease with dependent on dialysis. R3's Minimum Data Set, dated dated dated [DATE] showed R3 cognitively intact. On 10/22/2024 at 12:30 PM, R3 was in bed and said a cardiac monitor patch was applied to her because she was feeling dizzy and has a history of atrial fibrillation. R3 said her heart monitor was removed a few weeks ago, and V9 (Nurse Practitioner Cardiology) could not find the result. R3's Physician order dated 09/13/2024 showed R3 to have a 14-day (Heart monitor patch), return on 09/25/2024, place all equipment in a self-addressed pre-paid box, mail it back, and check with V9 (Nurse Practitioner Cardiology) for any questions. On 10/23/2044 at 11:46 AM, V9 (Nurse Practitioner Cardiology) said R3 was ordered a (heart monitor patch) for syncope episodes during therapy, and R3 has a history of atrial fibrillation. V9 said the (heart monitor patch) detects irregular heartbeats in the Electrocardiogram (ECG) data and helps to have a plan of care. V9 said the heart monitor was supposed to be sent on 09/25/2024 to the heart monitor company, and V11 (Facility Nurse Practitioner) removed and packed it on the same day. V9 said she kept looking for the results and followed up with the cardiac department and came to know that they never received the heart monitor. V9 said she escalated to V2 (Assistant Director of Nursing) and V1 (Administrator) and was upset about the situation. V9 further said R3 has very complicated cardiac conditions with multiple medications, and unnecessarily, R3's plan of care was delayed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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	10/24/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/2024 at 12:10 PM, V11 (Facility Nurse Practitioner) said on 09/25/2024, she removed the (heart monitor patch) from R3, put it in the box, per return label instructions, sealed it, and handed it over to V12 (Receptionist) around 11:00 AM - 11:30 AM, and she came to know that the device is pending return from the facility. V11 said R3 has very fluctuating blood pressure and heart rate with a history of A-fibrillation, and it takes two weeks for the result, and the result is very important for the plan of care. On 10/23/2024 at 12:20 PM, V12 (Receptionist) and V13 (Payroll staff) said when V11 brought the packet, UPS had already left for the day, and V12 had left for vacation. The next day, when V13 (Payroll staff) was covering for V12, she did not find any packets by the reception area, so she assumed United Parcel Service (UPS) picked them up. V12 said recently, when it came to his notice, he researched, and there was no UPS tracking number available. On 10/23/2024 at 1:07, V1 (Administrator) and V2 (Assistant Director of Nursing) said they found the sealed packet in the 3rd floor nursing station. V2 said no one knew why it was there or why no one noticed. V1 and V2 said the facility should have sent the device in a timely manner. 2. The EMR (Electronic Medical Record) showed R2 was a [AGE] year-old male with diagnoses including congestive heart failure, hypotension, morbid obesity, arterial tortuosity syndrome (congenital connective tissue syndrome), which causes complications in medium-sized arteries including aorta, and acute kidney failure. R2's Minimum Data Set, dated dated dated [DATE] showed R2 cognitively intact, and R2 was discharged home on 09/28/2024. A physician order dated 04/03/2024 showed R2 having a [NAME] Monitor. R2's [NAME] monitor was returned to the cardiology company for the result without a cell phone, and R2 received a bill for the missing cell phone. On 10/23/2024 at 12:10 PM, V11 (Facility Nurse Practitioner) said all heart monitors come with a proper return label with instructions, and whoever removes one should follow the instructions. On 10/23/2024 at 2:00 PM, V1 (Administrator) said not all heart monitors come with a phone, and R2's device came with a cellphone. V1 and V2 said whoever removed the heart monitor did not pack the device with the cell phone to mail it. V1 said R2 called him about the concerns a week ago, and he found the cell phone today and said he would return it to the company. The facility policy titled Policy/Procedure dated 07/2020, with the subject Physician Orders, in part showed that Licensed Professional Nurses and Registered Nurses would follow orders from physicians.