

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/18/2024
NAME OF PROVIDER OR SUPPLIER  Pearl of Hinsdale, The		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384</b></p> <p>Based on observation, interview, and record review, the facility failed to provide ADL (Activities of Daily Living) care for 3 residents (R87, R123, &amp; R65) who are dependent on care for daily living in a sample of 28.</p> <p>The findings include:</p> <p>1. On 10/15/24 at 11:19 AM, R87 was observed with long fingernails, about 1/4 inch over nailed and a brownish blackish substance under the nails, and R87's legs were observed with dry flaking skin. At 12:15 PM V25 CNA (Certified Nurses' Assistant) brought R87 his lunch tray but did not offer to clean his hands or assist in cleaning them before serving him his food. On 10/17/24 at 10:23 AM, R87's fingernails were observed long and with a brownish colored substance under the nails.</p> <p>R87's 8/21/24 ADL care plan showed that R87 has an ADL self-care performance deficit related to an impaired balance, decreased strength and endurance, weakness, decreased cognitive and communication skills secondary to stroke with residual deficits with diagnoses including altered Mental Status, CHF (congestive heart failure), and seizure. R87's care plan showed interventions including staff will provide sponge bath when a full bath or shower cannot be tolerated. R87's 10/9/24 MDS (minimum data set) section C showed that R87's mental status is cognitively impaired. R87's 10/2/24 MDS section GG showed that R87's needs supervision or touching assistance with personal hygiene. On 10/17/24 at 11:30 AM a review of R87's last 30 days of progress notes did not show any documentation of R87 refusing ADL care including nail care.</p> <p>2. On 10/15/24 at 11:36 AM, R123 was observed with his fingernails long, jagged, and with a brown substance under the nails. R123 said that the physical therapist clipped his nails a couple weeks ago. R123 said that when he moved into his room [ROOM NUMBER] weeks ago his personal nail grooming items were lost. On 10/15/24 at 12:28 PM, V25 gave R123 his lunch tray and did not offer to clean his hands. At 12:33 PM, R123 said he would have liked for the staff to offer to assist him in cleaning his hands before eating. R123 said that nobody has ever offered and thought that it would be automatic. On 10/17/24 at 10:21 AM, R123 was observed with his fingernails long and with a brown substance under the nails.</p> <p>(continued on next page)</p>

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
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R123's 8/6/24 MDS section GG showed that R123 needs partial/moderate assistance with personal hygiene. R123's 7/26/24 care plan showed that R123 has an ADL self-care performance deficit related to decreased balance, decreased gait, decreased strength and endurance, decreased activity tolerance following hospitalization with multiple medical conditions and comorbidities. The interventions include R123 will improve current level of function in hygiene through the review date.</p> <p>On 10/17/24 at 02:07 PM V3 ADON (Assistant Director of Nursing) said that she expects residents' nails to be cleaned, cut, and filed if needed, and resident's hands should be cleaned before eating. V3 said this should be done for cleanliness and infection control.</p> <p>The facility's Activities of Daily Living policy dated 7/20/2024 showed that the facility ensures that the residents receive ADL assistance and maintains resident's comfort, safety, and dignity. The policy showed that the facility will assist the resident to be clean, neat and well-groomed including nail care . as needed.</p> <p>45906</p> <p>3. On 10/15/24 at 12:24 PM, R65 said her whiskers on her chin bother her and she wants them removed. R65's chin hairs were a quarter inch to half an inch long and gray. R65 also had long dark nose hairs sticking out of her nostrils. R65 told surveyor that her chin hairs, bother the heck out of her because they are for men, not women. V1 (Administrator) was notified that R65 was requesting to have her chin hairs removed. On 10/17/24 at 11:46 AM R65 was observed lying in her bed, still with hairs on her chin. R65 said no staff had come in to help her remove her chin hairs and she still wanted the chin hairs taken care of.</p> <p>On 10/17/24 at 2:29 PM, V1 (Administrator) said he spoke to multiple staff members on 10/16/24 and R65's chin hairs had been removed. Surveyor told V1 that R65's chin hairs had not been removed. V1 and surveyor then walked together to R65's room and verified that R65 still needed her chin hairs removed.</p> <p>R65's Care Plan dated 8/11/23 shows she has a self-care performance deficit related to decreased strength and diagnosis of dementia.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>34410</p> <p>Based on observation, interview, and record review, the facility failed to implement fall precaution interventions for residents at risk for falls.</p> <p>This applies to 3 of 3 residents (R5, R103, and R87) reviewed for accidents and supervision in a sample of 28.</p> <p>46003</p> <p>1. R103 admitted to the facility with diagnoses of osteoarthritis of both knees, methicillin resistant staphylococcus aureus, morbid obesity, heart failure, lymphedema, hypotension, sleep apnea, chronic kidney disease, and hypertension. R103 current care plan states she is at risk for fall interventions include staff to assess the physical environment, device including furniture bed to ensure that they don't pose a safety hazard. Bed in a safe level position based on residents needs / risks. R103 MDS (Minimum Data Set) dated 9/28/24 shows she is dependent on staff for transfers and uses a manual wheelchair for mobility.</p> <p>On 10/15/24 at 11:08 AM, R103 was lying in bed with the bed and over-bed table in the highest position. R103 stated her bed was left in that position after her brief was changed.</p> <p>On 10/16/24 at 04:07 PM, R103 was lying in bed with the bed and over-bed table in the highest position. R103 stated her bed was raised to the high position so the CNA (Certified Nursing Assistant) wouldn't hurt his back and the nurse would be coming in at some time for the dressing change.</p> <p>On 10/16/24 04:07 PM, R20 CNA/ Wound Tech was called into R103's room. R20 stated the bed was not in a safe position. R103 could fall from the bed and be injured. The bed and table should have been left in a lower position.</p> <p>2. R5 admitted to the facility with diagnoses that includes intervertebral disc degeneration, osteoarthritis, chronic respiratory failure, type 2 diabetes, morbid obesity, cervicgia, chronic kidney disease, anemia, major depressive disorder, transient ischemic attack, blindness in one eye, lymphedema, dependence on supplemental oxygen, and obstructive sleep apnea. R5's current care plan states she is at risk for falls. Interventions include staff checking to ensure she is properly and safely positioned in bed. R5's MDS (Minimum Data Set) date 8/28/24 shows she uses a wheelchair for mobility and is dependent on staff assistance for transfers.</p> <p>On 10/15/24 at 12:15 PM, R5 was lying in bed with the bed and over-bed table in the highest position.</p> <p>On 10/16/24 04:17 PM, V19 CNA assigned to R5 stated she left R5's bed and over-bed table high after she took her vital signs and brought her water. V19 stated no one ever talked to her about the beds position when she leaves the resident's bedside. V19 stated no one ever told her R5's bed should not be left in a high position.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/17/24 at 01:25 PM, V2 DON (Director of Nursing) stated staff should make sure patients are safe. The bed should be in a low position if they are a high risk for fall and make sure fall interventions are in place. Staff should make sure the resident's belongings are in reach and bed is positioned safely. R103 is not able to self-transfer, and she is care planned as a fall risk. Her bed and table should be in the lowest position when staff walk away from her. R5 can have episodes of confusion. R5 is at risk for falls. V2 did not know of any occasion of R5 refusing to have her bed or over-bed table lowered. Staff should be lowering her bed and over-bed table.</p> <p>The facility policy Repositioning a Resident dated 7/15/24 states to lower the bed into safest and most comfortable position for resident.</p> <p>The facility policy Fall Prevention and Management dated 4/8/24 states all residents and patients will be considered at risk for falling, regardless of fall risk score. Universal fall precautions interventions will be implemented to all.</p> <p>41384</p> <p>3. On 10/15/24 at 11:23 AM, R87 was observed in his bed with his bed in a high position. Staff who only identified himself as PT (Physical Therapist) was in the room next to R87's bed but then left the room and left R87's bed in a high position.</p> <p>R87's 8/21/24 care plan showed that R87 is at risk for falls secondary to impaired balance, decreased strength and endurance, weakness, decreased cognitive and communication skills secondary to stroke with residual deficits, with diagnoses including altered Mental Status, CHF (congestive heart failure), seizures, and the use of hypoglycemic, and cardiac medications. The interventions include positioning, staff will check residents' location and activity to ensure resident is properly and safely positioned in bed or chair/wheelchair.</p> <p>On 10/17/24 at 02:05 PM, V3 ADON (Assistant Director of Nursing) said that her expectations are that residents' beds are not left in a high position because it is a fall risk.</p> <p>The facility's Fall Prevention and Management policy dated 4/8/2024 showed that the facility maintains a safe patient environment. The policy shows that interventions for High Risk Precautions included, interventions will be in place based on identified and assessed risk factor.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40054</p> <p>Based on observation, record review, and interview, the facility failed to complete accurate post-dialysis weights for residents on dialysis treatments.</p> <p>This applies to 5 of 7 residents (R41, R49, R91, R107, and R138) reviewed for dialysis in a sample of 28.</p> <p>Findings include:</p> <p>The dialysis service policy titled Monitoring and documentation pre, during, and post-treatment, dated 06/2018, in part, showed that the post-dialysis assessment would include post-dialysis weight. The registered nurse will do the post-dialysis assessment before the resident is discharged from the treatment area, and a copy of the completed dialysis communication form will be given to the unit staff after the resident's dialysis treatment.</p> <p>On 10/16/2024 around 11:00 AM, V21 (Registered Nurse dialysis) said staff either check the post weight at the dialysis unit or some time at the unit by the Certified Nursing Assistants, and staff let V21 know to complete the dialysis communication report, and then V21 provides the dialysis communication form to the unit nurse to enter the post dialysis weight readings in the EMR (Electronic Medical Record)</p> <p>1. Observed R41 having dialysis on 10/16/2024 around 10:30 AM, and after the completion of the dialysis treatment, R1 was transferred to the unit without taking post weight. The review of the record for Resident 41 showed R41 had diagnoses including end-stage renal disease and dependence on renal dialysis, morbid obesity, pleural effusion, cardiac diseases, and dependence on oxygen. R1 was admitted on [DATE] with continuing dialysis treatment three times per week on Monday, Wednesday, and Friday. R41's Minimum Data Set, dated dated [DATE] showed that R41 is cognitively moderately competent and required one to two maximum assistances for daily living activities. During the interview, R41 said the facility staff weighed before transferring her to the dialysis treatment unit, and she was never weighed after the treatment either at the dialysis center or by the unit staff.</p> <p>2. On 10/16/2024, around 4:30 PM, R138 was wheeled from the dialysis treatment to his room. R138 said the unit staff weighed him before the dialysis treatment, and he was never weighed after the treatment. The review of the record for R138 showed he had diagnoses including end-stage renal disease and dependence on renal dialysis, cardiac diseases, and HIV. R138's Minimum Data Set, dated dated [DATE] showed R138 cognitively competent and required one assist for daily living activities.</p> <p>3. On 10/16/2024 observed R49 in her room after the dialysis treatment, and R1 was interviewable and said she was weighed before the dialysis treatment and never weighed either by the dialysis staff or the unit staff after the dialysis treatment. The review of the record for Resident 49 showed she had diagnoses including end-stage renal disease and dependence on renal dialysis, diabetes, and cardiac diseases. R49's Minimum Data Set, dated dated [DATE] showed R49 cognitively impaired and required one staff assist for the activities of daily living. V24(Licensed Practical Nurse) entered R49's weights from the communication form to the EMR. V24 said she was entering the numbers from the communication form and was unsure who was weighing residents' weights after the treatments.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. On 10/16/2024, R107 was observed having dialysis treatment around 11:30 AM, and after the treatment, R107 was transferred to the unit without weighing post weight. R107 was interviewable and said she was weighed before the dialysis treatment and never weighed either by the dialysis staff or the unit staff after the dialysis treatment. The review of the record for Resident R107 had diagnoses that included end-stage renal disease and dependence on renal dialysis, diabetes, and cardiac diseases: morbid obesity and cirrhosis of the liver. The Minimum Data Set, dated dated dated [DATE] showed that R107 was cognitively intact and required one staff member to assist with daily living activities.</p> <p>5. On 10/16/2024, R91 had dialysis treatment around 3:30 PM, and after the treatment, R91 was transferred to the unit without recording post-weight. R91 was interviewable and said she was weighed before the dialysis treatment and never weighed either by the dialysis staff or the unit staff after the dialysis treatment. The review of the record for Resident R107 had diagnoses that included end-stage renal disease dependence on renal dialysis and heart failure. Minimum Data Set, dated dated dated [DATE] showed R91 cognitively intact and required supervision from one staff assistant for the activities of daily living.</p> <p>On 10/16/2024, at 11:00 AM and 11:45 AM, V25 and V26 (Certified Nursing Assistants), who transferred residents from the dialysis unit, said they never weighed residents after the dialysis treatment. At 12:00 PM, V21 (Registered Nurse Dialysis) acknowledged she was subtracting Residents' weights from the set ultrafiltration goals on dialysis machines and added standard 500 ml saline prime, which is the practice.</p> <p>On 10/17/2024 at 9:53 AM, V5 (Registered Nurse) said Certified Nursing Assistants are responsible for weighing residents before the dialysis treatments unit nurses complete the dialysis pre-assessments in the communication form, and Dialysis nurse completes the post-assessment communication form, including post weights. V5 said she was unaware that residents were not weighed after the dialysis treatments. V5 said if the dialysis pre and post-weights are not accurate, renal residents can get into hypovolemia or fluid overload complications.</p> <p>On 10/17/2024 (the Director of Nursing) said she was unaware of who was weighing residents after the dialysis treatment. V2 said it is important to comply with policy and prevent post-dialysis-related complications.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>41384</p> <p>Based on observation, interview, and record review, the facility failed to appropriately store and secure medications and biologics safely for 2 residents (R19 &amp; R93) who were reviewed for medication storage in a sample of 28.</p> <p>Findings include:</p> <p>1. On 10/15/24 at 01:38 PM 1 unopened package of albuterol sulfate 0.5% 2.5 mg / 0.5ml (milligram/milliliter), 1 albuterol sulfate 0.5% 2.5mg/0.5ml vial, not in the package, and 1 white pill in a medication cup was observed on R19's overbed side table. R19 said that the nurse had left the pill for her, and she did not know what the medication was for. Then R19 swallowed the pill. R19 said that the nurse leaves the albuterol sulfate for her every day, and she does the treatments herself.</p> <p>On 10/16/24 at 12:03 PM, a record review was done of R19's electronic health record, and it did not show any order to have medications at bedside, an assessment for self-medication, or an order to self-medicate.</p> <p>On 10/17/24 at 02:22 PM V3 ADON (Assistant Director of Nursing) said that R19 should not have medications left at her bedside because R19 doesn't have an order to self-medicate, and it is a safety issue. V3 said the facility cannot ensure that R19 received her medications as prescribed if the nurse does not give the medication to the resident. V3 said that there is a potential of someone else getting control of the medication because it is not being properly stored or secured.</p> <p>46003</p> <p>2. R93 admitted to the facility with diagnoses that includes chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia and hypercapnia, emphysema, hypoxemia, hypertension, major depressive disorder, anemia, and nicotine dependence. R93 current care plan states the resident is at risk for adverse reaction related to medication error. Interventions include educate the nurse to observe the 6 rights of medication administration. R93's MDS (Minimum Data Set) dated 9/27/24 indicates he is cognitively intact.</p> <p>On 10/15/24 at 11:32 AM, R93 had two ampules of duo-neb (Ipratropium - Albuterol) at his bedside. R93 stated he does his own nebulizer treatments three times per day. R93 stated the nurse gave him the duo-neb ampules. R93 stated the nurses don't follow up to see when he does his nebulizer treatment. R93 stated it is up to him to do administer them on his own.</p> <p>On 10/17/24 at 10:48 AM R93 stated he didn't have the duo-neb ampules anymore because he had used them. R93 he can have them every four hours as needed, and he last self-administered his duo-neb at 10pm the previous night.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/17/24 at 10:58 AM, V17 LPN (Licensed Practical Nurse) stated R93 can have his duo-neb every four hours as needed. When V17 reviewed the EMR (Electronic Medical Record) she was unable to find a current order for duo-neb. The medication cart had 9 ampules for R93 dated 6/25/24. V17 stated she never allowed R93 to self-administer his medication and she did not know who gave them to him. V17 LPN stated he did not have an assessment to keep medication at the bedside for self-administration.</p> <p>On 10/17/24 at 01:25 PM, V2 DON (Director of Nursing) stated R93 did not have an assessment to self-administer medications. R93 hasn't had an order for duo-nebs since August. The medications should not have been in his possession or still on the medication cart. V2 stated R93 is alert but did not have an order to self-administer medication and it should not have been in his possession.</p> <p>R93's order for duo-neb (ipratropium-albuterol) 0.5-2.5 (3) MG (Milligram)/ 3ML (Milliliters) 1 inhalation inhale orally every 6 hours as needed for SOB (Shortness of Breath) give over 10 minutes was discontinued 8/15/24.</p> <p>The facility policy Self- Administration of Medication dated 10/25/14 states for those residents who self-administer, the interdisciplinary team verifies the resident's ability to self-administer medications by means of a skill assessment conducted on a quarterly basis or when there is a significant change in condition. The resident is asked to complete a bedside record indicating the administration of the medication if bedside storage is to be used.</p> <p>The facility policy Medication Administration dated 4/18/24 states medications will not be left at bedside unless with order from physician.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>46003</p> <p>Based on observation, interview and record review the facility failed to assure residents were not served food items to which they had allergies or sensitivities and follow up on a resident's food preferences. This applies to 2 of 4 residents (R40 and R30) reviewed for food concerns in a sample of 28.</p> <p>Findings include:</p> <p>1. R40 admitted to the facility with diagnoses that includes atrial fibrillation, cognitive communication deficit, pneumonitis due to inhalation of food and vomit, anemia, anxiety, bipolar disorder and celiac disease. R40's MDS (Minimum Data Set) dated 7/27/24 indicates she has moderate cognitive impairment. R40's current diet order is general diet regular texture, regular consistency, gluten free / restricted. R40's current care plan states she has bowel incontinence related to celiac disease. R40 has a nutritional problem related to celiac disease. Interventions include to provide and serve diet as ordered.</p> <p>On 10/15/24 at 12:35 PM, R40's lunch meal ticket read: allergy red dye, gluten / wheat. Main menu vegetarian / vegan option, green peas, no sub found for apple crisp beverage of choice. R40's meal included a brown patty, green peas and a serving of apple crisp.</p> <p>On 10/17/24 at 12:27 PM, R40's meal included pork in gravy, rice pilaf, mixed vegetables, cranberry juice and red gelatin with fruit. While eating the gelatin R40 began coughing. V19 CNA (Certified Nurse Aide) came to R40 and looked at her meal ticket with surveyor. The meal ticket read allergy red dye, gluten / wheat. Pork chop no breading, rice pilaf, broccoli florets, no sub found for dinner roll no sub found for fruited gelatin beverage of choice. V19 took the gelatin and cranberry juice and gave R40 plain water. V19 stated she did not know if the gelatin and cranberry juice had red dye in them.</p> <p>On 10/17/24 at 01:08 PM, V12 Dietary Manager stated she did not have a recipe for the gravy that was served on the pork. The cook and three dietary aids plate the food and check the meal ticket for allergies. V12 stated that flour has gluten in it and the cook and staff are aware. V12 there is only one resident with a gluten allergy. V12 stated the gelatin did have red dye. If an allergy to gluten the resident should not get the gravy. If the resident has a red dye allergy, they should not get the gelatin.</p> <p>On 10/17/24 at 01:13 PM, V14 [NAME] stated the pork gravy was made from pork drippings, salt, pepper, garlic, flour and a little cold water. V14 stated he only made one type of gravy and did not make a special gravy for anyone.</p> <p>Review of the recipe for apple crisp lists all-purpose flour as one of the ingredients. Review of the gelatin product ingredients includes red 40 and red 40 lake.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. R30 admitted to the facility with diagnoses that includes chronic obstructive pulmonary disease, dermatitis, hypertension, severe protein calorie malnutrition, gastro-esophageal reflux disease and adult failure to thrive. R30's MDS (Minimum Data Set) dated 9/13/24 indicates she is cognitively intact. The current care plan states R30 has abdominal pain related to an ileus. Interventions include to monitor, record and report to the nurse loss of appetite or refusals to eat. R30's current physician diet ordered is general diet mechanical soft texture, regular thin consistency, super cereal at breakfast, nutritional treat with lunch, pudding with dinner. Dietician to re-evaluate for food preferences.</p> <p>On 10/15/24 at 12:52 PM, R30 stated she got apple sauce, gelato and apple juice but she couldn't eat them because it would upset her stomach. She stated she is sensitive to dairy too. R30 stated if she told them she wouldn't get anything to eat or drink.</p> <p>On 10/17/24 at 10:29 AM, R30 stated got a banana for breakfast but gave it back to the CNA. R30 stated she had not seen the dietician at all this year as far she could recall.</p> <p>On 10/17/24 at 10:29 AM, V18 Family Member stated fruit doesn't agree with R30 as it gives her runny bowels / diarrhea.</p> <p>On 10/17/24 at 12:53 PM, R30 got gelatin with fruit, apple juice and milk on her lunch tray.</p> <p>On 10/17/24 at 10:54 AM, V16 CNA stated R30 did give her the banana back at breakfast. R30 will usually give the gelato and banana back and give the juice to the housekeeper. R30 mainly drinks coffee and water. V16 stated she didn't know why R30 sent the items back and she didn't want to know why.</p> <p>On 10/17/24 at 10:58 AM, V17 LPN (Licensed Practical Nurse) stated R30 did not have any food allergies on her chart. An order was entered on 4/9/24 for the dietician to see R30 for food preferences. V17 did not find any documentation that the dietician had seen R30 since the order was entered.</p> <p>On 10/17/24 at 01:25 PM, V2 DON (Director of Nursing) stated There was an order from April 2024 for the dietician to follow up with R30 for food preferences. If the dietician had seen her there would be a progress note or an assessment done. V2 did not find any progress notes or assessments by the dietician since the order was entered. V2 stated the nurse or nurse manager should have reached out to the dietician to follow up with the resident.</p> <p>On 10/17/24 at 02:22 PM, V15 Dietician stated she did not know at that moment if she or the aide had seen R30 or if she had been notified of a follow up. V15 stated nursing notifies her of new orders. V15 stated if she had been seen there would be a progress note or assessment documenting the follow up.</p> <p>The facility policy Food and Nutrition dated 4/17/24 states it is the policy of the facility to ensure that facility staff support the nutritional wellbeing of the residents while respecting an individual's right to make choices about his or her diet. The facility will provide each resident with a nourishing, palatable, well- balanced diet that meets his or her daily nutritional and special dietary, needs taking into consideration the preferences of each resident.</p>		

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NAME OF PROVIDER OR SUPPLIER  Pearl of Hinsdale, The		STREET ADDRESS, CITY, STATE, ZIP CODE  600 West Ogden Avenue Hinsdale, IL 60521	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45906</p> <p>Based on observation, interview, and record review, the facility failed to properly label, date, seal, and store food items in the kitchen.</p> <p>This applies to all resident that receive oral nutrition and foods prepared in the facility kitchen.</p> <p>Findings include:</p> <p>The Facility Resident Census and Condition of Residents (Form CMS-Centers for Medicare and Medicaid Services-672) dated [DATE] documents the total census was 138 residents. On [DATE] at 11:33 AM, V12 (Dietary Manager) said there are 3 NPO (Nothing by Mouth) residents and the rest of the residents eat from the facility kitchen.</p> <p>On [DATE] starting at 10:24 AM, the facility kitchen was toured. Starting at 10:37 AM, V13 (Regional Dietary Manager) was present for the tour. The following was found:</p> <p>At 10:53 AM in walk-in cooler #1:</p> <ol style="list-style-type: none"> <li>1. 2 large pork roasts, no label and no date</li> <li>2. 5- 10 pound packages of 73% lean and 27% fat ground beef with best before or freeze by date of [DATE]. V13 (Regional Dietary Manager) said the staff told her the ground beef was thawed a couple days ago. The meat was all completely thawed and there was no other date on the meat besides [DATE].</li> <li>3. A 5 pound tub of cottage cheese with sell by date of [DATE]rd. V13 said cottage cheese was not safe to serve.</li> <li>4. A meatloaf dated [DATE]. V13 said the meatloaf expired [DATE].</li> <li>5. 17 tomatoes that are soft/rotten with multiple black spots on them. V13 pointed to one of the tomatoes and said, this one is moldy.</li> <li>6. A medium sized silver bin of marinara sauce dated [DATE]. V13 said the sauce was expired on [DATE].</li> <li>7. A 10 pound tub of potato salad with best before [DATE]. Expired.</li> </ol> <p>At 10:39 AM in walk-in cooler #3:</p> <ol style="list-style-type: none"> <li>8. A crate of 27 4 ounce milk cartons that were warm to touch. Surveyor asked V13 to check the temperature of the milk and it showed 68 degrees.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>9. A single mango sitting on wire rack. Mango is soft/mushy with the imprint of the wire rack on it when picked up and is sticky on the outside. V13 said she did not know where the mango came from because mangoes are not a part of their menu.</p> <p>10. A plastic grocery store bag with partially thawed pork chops in it. Outside of the bag wet and sticky- resting on second from top rack above a cardboard box of hamburger buns. A staff member came into the cooler and told V13 the pork chops were his personal food items that he purchased for his home. V13 gave him the bag of meat.</p> <p>11. A half loaf of raisin bread, firm to touch, dated [DATE].</p> <p>At 10:27 AM in the dry storage:</p> <p>12. ,d+[DATE] pound rainbow sprinkle cartons expired on [DATE].</p> <p>13. An opened 5 pound bag of instant dry milk crystals labeled ,d+[DATE] and use by ,d+[DATE].</p> <p>14. A large opened, not sealed bag of croutons.</p> <p>15. An unlabeled opened/punctured 2 pound bag of what appears to be rice that is spilling out over the floor and has expiration date of [DATE].</p> <p>16. 3 unlabeled and undated medium sized plastic bags of brown powder- appears to be cake mix.</p> <p>At 11:15 AM in walk-in freezer:</p> <p>17. 10 hamburger patties in plastic bag not sealed, hole ripped in bag.</p> <p>On [DATE] at 11:19 AM, V12 (Dietary Manager) said all the food items in the kitchen need to be labeled and dated for food safety. V12 said it is the policy that every food item coming into the kitchen needs to be labeled and dated to make sure the food is safe to serve the residents and does not cause foodborne illness. V12 said all food items need to be sealed properly to prevent contamination to the food item from environmental contaminants. V12 said expired items should be thrown away as soon as possible, by the expiration date. V12 said all items in the refrigerator should be kept below 40 degrees and milk that goes above 41 degrees is not safe to serve to the residents as it may cause diarrhea, stomach upset, or food poisoning. V12 said staff can absolutely not store their personal food items in food storage designated for residents because of the risk of foodborne illness/contamination to resident food. V12 said when kitchen staff move food items from the freezer to the cooler to thaw, they need to date the item with a thaw date so staff now how much longer the item is safe to serve.</p> <p>The facility's policy titled, Food Storage last reviewed [DATE] states, Policy: All food stock and food products are stored in a safe and sanitary manner. All food stock is dated . Procedure: .7. Food stock and prepared food products are stored at safe temperature ranges at all times. 8. All protein items (i.e. meat, poultry, fish) are defrosted under refrigeration on the bottom shelf. 9. All food stock and products are stored . covered, labeled as to contents, and dated .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility's policy titled, Labeling and Dating Foods last reviewed on [DATE] states, Policy: To decrease the risk of food borne illness and to provide the highest quality, foods are labeled with the date received, the date opened and the date by which the item should be discarded. Procedure: Canned food and other than shelf stable items such as cake mixes are labeled with the date received. If the product does not have an expiration date, the product is labeled with a discard or use by date .</p> <p>The facility's policy titled, Personal Food Storage last reviewed [DATE] states, Policy: Food items brought in by staff shall be stored in designated areas only. Procedure: 1. Food brought in by staff will be identified with the name of owner and date placed in designated refrigerator .4. Placing personal food items in any area other than specific designated area shall be subject to progressive disciplinary policy .</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>45906</p> <p>Based on observation, interview, and record review, the facility failed to properly contain and cover garbage in the facility kitchen to control fruit fly population.</p> <p>This applies to all residents that receive oral nutrition and foods prepared in the facility kitchen.</p> <p>Findings include:</p> <p>The Facility Resident Census and Condition of Residents (Form CMS-Centers for Medicare and Medicaid Services-672) dated 10/15/24 documents the total census was 138 residents. On 10/15/24 at 11:33 AM, V12 (Dietary Manager) said there are 3 NPO (Nothing by Mouth) residents and the rest of the residents eat from the facility kitchen.</p> <p>On 10/15/24 at 10:24 a large black garbage can was observed uncovered in the main kitchen area with at least 2 fruit flies seen flying above the garbage can. On 10/15/24 at 11:19 AM in the Dish Room, a large black garbage can was seen uncovered with food debris in it and swarms of an estimated 10-20 fruit flies flying around it. No staff were doing dishes in the dish room at that time, the room was not occupied and garbage can was left with food in it, uncovered. V13 (Regional Dietary Manager) said we do have a problem with flies. This garbage can remained uncovered with fruit flies flying in and out and around and above it through 11:29 AM when surveyor and V13 left the dish room. On 10/16/24 at 11:07 AM, large black garbage can was seen in the dish room flipped upside down with no bag in it and no lid on it. An estimated 2-3 fruit flies were seen in the dish room at this time. On 10/17/24 at 11:19 AM, an estimated 2-3 fruit flies were seen flying in the hall right outside of the kitchen entrance.</p> <p>On 10/17/24 at 11:19 AM, V12 (Dietary Manager) said fruit flies had been a problem in the kitchen on and off for at least the past six months since she started working at the facility. V12 said garbage cans should be kept covered because garbage can release gas into the air, there could be splashes, and having an uncovered garbage can cause/attract more fruit flies.</p> <p>The facility provided Service Inspection Reports for Pest Control show that fruit flies were found in the main kitchen, the kitchen dish room or both places on 8/30/24, 9/19/24, 9/30/24, and 10/10/24.</p> <p>The facility's policy titled, Pest Control last reviewed on 6/20/24 states, 1. INTENT: Provide a healthy environment for residents. Typical pests include: .Other common pests found in long-term care facilities include: .flies .Interior .Cover and seal bulk food storage containers and garbage containers. Keep trash cans lined and empty them regularly .</p> <p>The facility's policy titled, Garbage and Rubbish Disposal last reviewed 9/3/24 states, Policy: Garbage and rubbish shall be disposed of in accordance with current state laws regulating such matters. Procedure: 1. All garbage and rubbish containing food wastes shall be kept in containers. 2. All containers shall be provided with tight fitting lids or covers and such containers must be kept covered when stored or not in use .</p> <p>(continued on next page)</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility's policy titled, Garbage Cans last reviewed on 9/3/24 states, Note: Always cover garbage cans when not in use .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34410</b></p> <p>Based on observation, interview, and record review, the facility failed to follow its Enhanced Barrier Precautions (EBP) Guidelines and isolation policy by staff not wearing gowns during incontinent care for an EBP resident and having visitors visiting contact isolation residents without having gloves or gown. The facility also failed to maintain effective hand hygiene during resident care.</p> <p>This applies to 3 of 3 residents (R51, R80, and R87) reviewed for infection control practices in a sample of 28.</p> <p>The findings include:</p> <p>1.</p> <p>R80 is a [AGE] year-old female admitted on [DATE]. As per the Minimum Data Set (MDS) dated [DATE], her cognition is intact.</p> <p>On 10/15/24 at 11:29 AM, R80's entry door was observed with an EBP sign to wear gloves, gown, and mask to provide high-contact resident care activities.</p> <p>On 10/15/24 at 11:35 AM, the writer observed V27 (Certified Nursing Assistant / CNA) and V28(CNA) providing incontinent care without wearing a gown as per the EBP sign posted on the entry door.</p> <p>On 10/15/24 at 11:44 AM, V27 stated that R80 was not assigned to her and was not aware of EBP with R80. V27 added that she was just helping V28 to provide incontinent care.</p> <p>On 10/15/24 at 11:46 AM, V28 stated that she didn't know that she should have worn a gown during incontinent care to R80.</p> <p>On 10/15/24 at 11:39 AM, V29 (Licensed Practical Nurse / LPN) stated, R80 is on EBP due to extended-spectrum beta-lactamase (ESBL) in urine. Changing R80's incontinent brief is considered a touch activity, and staff should wear gowns and gloves while providing incontinent care.</p> <p>A review of the facility presented Enhanced Barrier Precaution Guidelines revised on 3/28/24 document high contact activities include changing brief or assisting with toileting.</p> <p>2. R51 is a [AGE] year-old female with intact cognition as per the MDS dated [DATE].</p> <p>On10/15/24 at 10:21 AM, R51 was observed in a contact isolation room with a care giver without having gloves or gown and touching/rearranging resident belongings at bedside.</p> <p>10/15/24 10:47 AM, V29 (LPN) stated that R51 is on contact isolation due to extended-spectrum beta-lactamase (ESBL) in urine. Everybody goes in should wear gown and gloves. The care giver supposed to wear Personal Protective Equipment (PPE) when inside.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/15/24 at 02:25 PM, V2 (Director of Nursing / DON) stated that anybody going inside the contact isolation resident room including private care giver should wear PPE. Changing resident brief is considered a high contact activity and CNAs should have worn gown and gloves during incontinent care for EBP resident.</p> <p>A review of the facility presented isolation policy revised on 6/2/24 documented to provide and/or oversee the education of the resident, representative, and/or visitors regarding the precautions and use of PPE.</p> <p>41384</p> <p>3. On 10/15/24 at 11:22 AM R87 was in his bed and V25 &amp; V30 CNAs (Certified Nurses' Assistants) were observed changing R87's soiled bedlinen. V25 said that the linen was soiled with urine and food. V25 said that R87 spilled urine in his bed from his urinal. V25 and V30 had gloves on their hands but were never observed cleaning their hands and changing their gloves when going from a dirty item/area to a clean item/area. V25 and V30 were observed removing the soiled linen and putting clean linen on R87 bed and on R87. V25 and V30 were observed touching R87's body, bed control, TV control, blanket and call light with their dirty gloved hands. V25 picked up a clean incontinence brief and handed it to R87 for him to put on himself with her dirty gloved hands.</p> <p>4. On 10/15/24 at 12:00 PM V25 CNA, was observed with gloved hands providing incontinence care for R87. V25 was wiping stool from R87's buttocks, touching R87's blanket, removing his soiled brief and putting a clean brief on R87 without cleaning her hands in-between going from a dirty environment to a clean one.</p> <p>On 10/17/24 at 02:11 PM V3 ADON (Assistant Director of Nursing) said that the staff should have cleaned their hands and changed gloves when going from dirty to clean while providing incontinence care and changing linen for infection control.</p> <p>The facility's Incontinence Care policy dated 3/10/24 showed that staff should remove gloves and perform handwashing after removing soiled clothing and linen. The policy shows that after cleaning a resident during incontinence care staff is to remove their gloves and clean their hands then apply clean clothing and linen.</p> <p>The facility's Hand Hygiene Policy date 6/2/2024 showed that it is the policy of the facility to perform hand hygiene in accordance with national standards from the Centers for Disease Control and Preventions and the World Health Organization.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384</b></p> <p>Based on interview, observation, and record review, the facility failed to maintain residents' bed equipment.</p> <p>This applies to 2 residents (R87 &amp; R123) reviewed for maintenance of furnishings and equipment in a sample of 28.</p> <p>The findings include:</p> <p>1. On 10/15/24 at 11:28 AM, R87 was observed in his bed and his bed control had about 2 inches of exposed wires. On 10/17/24 at 10:11 AM, R87 was observed in his bed and his bed control was observed with about 3 inches of exposed wires.</p> <p>On 10/17/24 at 02:16 PM V3 ADON (Assistant Director of Nursing) said that R87's bed control should not have exposed wires because it is a safety issue. V3 said that it is her expectation for staff to report it.</p> <p>2. On 10/15/24 at 12:23 PM, R123 was in his bed, and he said that his bed control has not worked since he was moved into the room [ROOM NUMBER] weeks ago and he reported it. V25 CNA (Certified Nurse's Assistant) said that she reported it the day before, and the Friday before that. R123 said that the bed can only be adjusted by the staff at the foot of the bed. R123 said that a man came in earlier that day and looked at the bed controller, but he could not get it to work. On 10/17/24 at 10:11 AM, R123 was observed in his bed with the head of the bed flat. R123 said his bed controller was still not working. He said that he is not able to raise the head of his bed. Then V6 (Janitor) came into the room and tested the bed control and confirmed that it was not working.</p> <p>R123's electronic health record showed that he is a [AGE] year old male admitted to the facility on [DATE] with diagnoses including acute pulmonary edema, emphysema, fluid overload, pleural effusion, pericardial effusion, hypertension, and end stage renal disease. R123's 7/26/24 care plan showed that R123 has fluid overload and potential fluid volume overload with interventions including raise HOB (head of bed) as needed to facilitate breathing and increase comfort.</p> <p>On 10/17/24 at 02:18 PM, V3 ADON (Assistant Director of Nursing) said that her expectations are that R123 have a working bed control because of his conditions. V3 said that the bed control should have been taken care of as soon as it was identified especially because of his condition. V3 said that the facility could have gotten R123 a different bed if they couldn't get the control to work.</p> <p>The facility's Space and Equipment policy dated 3/22/2024 showed that the facility will maintain all mechanical, electrical and patient care equipment in safe operating conditions.</p>		