STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145350	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Rolling Meadows,the	4225 Kirchoff Road Rolling Meadows, IL 60008

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	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** 40102 Based on interview and record review, the facility failed to properly monitor/supervise a high fall risk resident and ensure safety during incontinence care. This affected one of three (R2) residents reviewed for safety during care. This failure resulted in R2 rolling out of bed suffering a laceration to the head which required six sutures at the hospital. Findings Include: R2 is a [AGE] year old with the following diagnosis: malignant neoplasm of the stomach, dementia, anxiety disorder, and repeated falls. An Incident note dated 6/5/24 documents the CNA (V10 - Former CNA) called the nurse's attention to R2's room. R2 was observed lying on R2's left side on the floor with a red substance noted on the floor. R2 stated that R2 rolled out of bed. Pressure was applied to the head by wrapping with gauze to stop the bleeding. 911 was called. The Hospital Records dated 6/5/24 document R2 presented to the emergency department with a fall. R2 reportedly was reaching for an item and fell off the bed, striking the left side of the head on the ground. R2 was found in a pool of blood and complaining of pain in the left arm. A 2 cm x 2 cm laceration was noted over the left temple with a large hematoma and was pulsating blood. The laceration was closed with six sutures. A CT scan of the head was negative as well as a left forearm x-ray. R2's family member refused for R2 to return to the facility so R2 was admitted for placement. On 7/30/24 at 3:06PM, V6 (Nurse) stated V10 called V6 into R2's room due to R2 falling from the bed. V6 reported R2 had a laceration to the left side of the head and blood was coming out of the wound. V6 stated asking R2 what happened to which R2 replied that R2 rolled out of bed. V6 stated R2 was asked first what occurred before asking V10. V6 reported V10 also stated that R2 rolled out of bed while V10 was providing incontinence care. V6 stated R2 was able to move around the bed but needed staff assistance to completely turn over. V6 reported the bed was not in the lowest position at the time of the fall due to R2 being changed so R2 fell from a higher level. (continued on next page)

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
	145350	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Rolling Meadows,the	4225 Kirchoff Road Rolling Meadows, IL 60008

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	On 7/30/24 at 3:40PM, V7 (Restorative Nurse) stated R2 was a high fall risk due to having multiple falls, poor safety awareness, confusion, and not being physically able to move as normal. V7 reported the fall on 6/5 was due to R2 rolling out of the bed while R2 was being changed. V7 stated per V10's statement, R2 was being restless and V10 turned to grab something and when V10 turned back around R2 was rolling out of bed. V7 confirmed an intervention of bed bolsters should have been in place at the time of the fall. V7 reported R2 was a one person maximum assist with bed mobility. V7 stated once R2 was turned to the side, R2 was able to hold the side rail and assist, but R2 wasn't able to turn R2's self. V7 reported a resident should never be left unattended while they are laying on their side for safety reasons. V7 said, The proper positioning in the bed and monitoring is just safer for the resident and helps prevent any falls. On 7/31/24 at 9:56AM, V8 (DON) stated first speaking with V6 who told V8 that R2 rolled off the bed while being changed. V8 reported to the speaking with V10 about the incident. V8 stated V10 said V10 was changing R2's brief and turned R2 to the right side and V10 then began reaching for a new brief. V8 reported not being sure of V10's exactly location but was somewhere along the bedside. V8 said, She (V10) let go of the resident for a second. The resident rolled over onto her back then off of the bed. V8 stated R2 lost R2's balance after R2 rolled to R2's back and fell off the bed. V8 reported R2 is a high fall risk due to poor safety awareness, needing assistance with ADL care, lack of mobility, and previous falls. V8 stated R2 is alert and oriented times two with confusion. V8 reported R2 is a substantial/maximum assist with bed mobility but is able to move some and grab onto the grab bar when turned. V8 described the positioning device that is mentioned in the reportable is like a side rail, but it's a quarter of the size. V8 stated the positioning aide helps the resident hold on when they're being turned. V8 reported V10 did walk out during the interview due to getting flustered and resigned at that time. V8 stated R2 was sent to the hospital and ended up getting sutures to the laceration. On 7/31/24 at 11:08AM, V9 (Primary Physician) stated R2 had a laceration to R2's head from a fall. V9 reported R2 was being changed and fell from the bed. V9 stated R2 is a one assist. V9 reported the CNA was reaching over for a brief and during this time, R2 somehow fell from the bed. V9 stated R2 only had the capacity to hold R2's body to the side. V9 was unaware if R2 was on R2's side or R2's back when R2 rolled out the back. V9 reported V10 just went to grab something and R2 ended up rolling off the bed. V9 said, I'm not exactly sure how this would happen. She probably lost her balance somehow. On 8/1/24 at 9:09AM, V8 was unaware if the bolsters were on the bed at the time of the fall but stated if they were on the care plan then they should have been on the bed. V8 said, I think she just turned too quickly over to her back then rolled to her side off the bed. V8 confirmed R2 did roll off the same side the CNA was standing on. V8 stated the CNA was grabbing a brief to put on R2 but never left the bedside per V10's interview. When asked how R2 was able to roll so quickly to R2's back, left side, and then over the bolster before V10 stopped R2, V8 responded, I don't know how she was able to roll onto her back and then onto the floor so quickly without the CNA stopping her. I don't know. V8 reported R2 is a substantial/maximum assist with bed mobility but R2 can begin to roll R2's self to the side. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145350	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Rolling Meadows,the	4225 Kirchoff Road Rolling Meadows, IL 60008

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	On 8/1/24 at 9:17AM, V6 stated both R2 and V10 confirmed R2 rolled out of the bed causing the fall but V6 was unsure of the exact manner to which R2 fell out of the bed. V6 was not able to recall if the bed bolsters were in place. V6 reported R2 was lying on R2's left side but was on the right side of the bed if you are facing the bed at the foot. V6 said, When you are changing a resident everything you need should be at the bedside. If you need to go get something you forgot then the resident should be put back in the middle of the bed and the bed lowered to the floor. You shouldn't be grabbing for things even if they are closer because it takes your attention away from the resident and then accidents like this can happen. The surveyor called V10 throughout the survey to obtain an interview regarding the incident but a call was never returned. The Fall Event dated 6/5/24 documents R2 fell in R2's room. R2 was lying in the bed getting R2's brief changed immediately prior to the fall. R2 reported that R2 rolled out of bed. R2 is able to respond verbally per baseline. An injury to the top of the scalp was noted with a red substance coming from the scalp. The SBAR Communication Form dated 6/5/24 documents R2 was transferred to the hospital due to a fall. The Fall Investigation Report dated 6/5/24 documents at 6:45 PM, the CNA called the nurse to R2's room. R2 was observed lying on R2's left side next to the bed. R2 was bleeding from the face head area on the left side where R2 was lying. Pressure was applied with gauze bandages. R2 stated that R2 rolled out of bed. 911 was called. R2 was oriented to person and place per baseline. Predisposing factors of the fall are poor safety awareness, periods of agitation and restlessness, weakness, and use of psychotropic medication. The root cause of the fall documents after further investigation, staff was providing incontinence care to R2. R2 was lying on the right side in bed. As the CNA was reaching for the incontinent brief, R2 abruptly turned over onto R2's back. R2 then continued turning and was not able to grab the positioning device for control to stabilize R2's balance causing R2 to roll out of bed and onto the floor. The Final Incident Report dated 6/11/24 documents R2 is a long-term resident that resides on the dementia unit. R2 is alert and oriented times two with periods of confusion. R2 is able to move in bed with the help of the positioning device and one staff assist. R2 was observed on the floor next to R2's bed with a laceration to the left temple with bleeding. R2 was sent to the hospital and was admitted with a hematoma to the left temple and required six sutures to the laceration to the left temporal area. The CNA that was providing care at that time of the fall reported R2 was lying on the right side in the bed and the CNA was standing behind R2 on the other side of the bed. As the CNA was reaching for the incontinence brief at the bedside, R2 abruptly turned over onto R2's back. R2 continued turning to the left side and was not able to grab the positioning device to stabilize R2's balance. This caused R2 to fall onto the floor on the same side where the CNA was standing. The x-ray and CT of the cervical spine and head were done at the hospital and showed no acute abnormality. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145350	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Rolling Meadows,the	4225 Kirchoff Road Rolling Meadows, IL 60008

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	The Fall Assessment 4/26/24 documents a score of 24 indicating R2 is at high risk for falls. R2 has a history of multiple falls, has poor memory and recall ability, is totally incontinent of both bowel and bladder, has agitated behavior, requires hands on assistance to move from place to place, and has a decrease in muscle coordination. The Fall Risk assessment dated [DATE] documents a score of 27 indicating R2 is a high fall risk. A score of 16 or above indicates a resident is at high risk for falls. The Restorative Nursing Program Documentation dated 4/26/24 documents R2 has impaired mobility due to decreased range of motion related to generalized weakness, poor trunk control, and poor safety awareness. The Care Plan dated 5/24/20 documents R2 is at risk for falls due to poor safety awareness related to cognitive impairment, impaired mobility, and generalized weakness. An intervention on 5/12/23 documents bed bolsters were put in place. The Care Plan dated 8/10/22 documents R2 has had an actual fall with no injury. An intervention documented on 5/12/23 documents staff will ensure that R2 is centered in bed, positioning device is functional and up as appropriate, floor mats are in place as appropriate, and trunk and extremities are properly aligned and supported. The Care Plan dated 8/24/23 documents R2 has had an actual fall on 8/24/23, 9/2/23, 9/10/23, and 9/14/23 with no injury. An intervention documented on 9/14/23 documents staff will ensure that R2 is centered in the bed, position device is functional and up as appropriate, bed bolsters are properly secured as appropriate, and trunk and extremities are properly aligned and supported. The care plan with no date documents R2 is challenged by dementia and mental illness which impedes on R2's safety awareness and judgment. This care plan also documents R2 has an ADL self-care performance deficit related to weakness. An intervention documents R2 requires limited to extensive assist by one staff to turn and reposition in the bed as necessary. The Minimum Data Set (MDS) Section GG dated 4/26/24 documents R2 is a substantial/maximal assist indicating the staff member does more than half of the effort. The staff member lifts or holds the resident's trunk or limbs, and provides more than half the required effort. R2 is dependent when going from a sitting to a lying position indicating the staff member does all of the effort. R2 is not ambulatory. The facility provided the surveyor with a drawing of the incident to describe where the CNA was standing in relation to R2, the bed, and how close the bedside table was to the bed. According to the description of the incident and drawing, R2 should not have been able to turn from R2's right side to R2's back and over to R2's left side before being stopped or assisted by the CNA that was allegedly standing directly next to the bed. With the description of the incident and drawing, it can be determined that R2 was not properly monitored or supervised while the CNA was providing incontinent care if R2 had enough time to roll from R2's right side to R2's back then continue rolling onto R2's left side over the bed bolsters and then out of the bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145350	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Rolling Meadows,the	4225 Kirchoff Road Rolling Meadows, IL 60008

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	The policy titled, Fall Prevention and Management, dated 4/8/24 documents, Policy Statement: the facility is committed to its duty of care to residence 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 .Fall Interventions: a. Universal fall precautions/facility fall protocol will be implemented to all residents and admitted to the facility, regardless of risk scores.