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	12/20/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33760 Based on interview and record review the facility failed to ensure a resident was free from physical abuse to 1 of 9 resident (R4) reviewed for physical abuse in the sample of 9. The finding include: R4's face sheet show R4 79 y/o that has diagnoses that includes dementia, wanderer, restlessness and agitation. R4's facility assessment dated [DATE] show R4 is severely cognitively impaired. The same assessment under section E (Behavioral Symptoms and frequency) show: [R4 has] Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others .) behavior of this type occurred 1-3 days Wandering . behavior of this type occurred 4-6 days R4's careplan with initiated date of 6/10/24 shows, R4 exhibits physically aggressive behaviors. R/t: cognitive deficit, dx of dementia, poor comprehension. Resident becomes combative unprovoked. He has bitten a staff members arm that required medical attention. He has grabbed a CNA who was trying to change him causing 2 broken finger nails. He will swing at staff when trying to provide care. He has attempted to take glasses off staff member and break them, he has hit staff on multiple occasions R/t: cognitive deficit, dx of dementia, poor comprehension The Facility Reported Incident sent to the state agency as final dated 11/6/24, (incident date 11/4/24) show, R4 (79 y/o) with dementia and behavioral disturbances. R3 (90 y/o) with Alzheimer and dementia .it was reported by the CNA (V4), R4 was trying to maneuver R3's wheelchair to fix as he does based on the history of his professional work. In the interaction, R4's right hand accidentally made contact with R3's face . The staff immediately separated both residents . (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/20/24 at 9:20 AM, R4 was in dining room sitting in a chair agitated. R4 was spitting everywhere in the dining room. V13 (Certified Nursing Assistant CNA) who was also in the dining room said R4 was like this, with behaviors-agitated, spits all over, can be aggressive and when R4 wanders, R4 was hard to redirect. V13 said R4 needed to be monitored closely. In the same dining room, R3 was quietly sitting in her wheelchair alert and pleasant. R3 said she was fine. On 12/20/24 at 9:35 AM, V3 (License Practical Nurse-LPN) said she was the Nurse working last 11/4/24 when the incident happened between R4 and R3. V3 (LPN) said she was in the Nurses station and can hear R4 and R3 yelling at each other at the opposite end of the hallway. Then she heard R3 screamed he hit me! he hit me! repeatedly. V3 said she went to check on them immediately, R3's left side of her face was reddened. They were both immediately separated. R4 was placed on 1:1. Both of their Physicians and family were notified. Facial X-ray's was ordered for R3 with no fractures noted. R4 was sent out to the hospital. R4 has behaviors of physical aggression. R4 should have been monitored closely and not get near R3. When a resident hit another resident that is abuse. At 9:50 AM, V4 (CNA) said R4 was up and about and wanders. R3 was in her wheelchair and able to wheel herself around the unit. On 11/4/24, both R4 and R3 were noted to be at the end of the hallway arguing and yelling at each other. R4 was wanting to push R3's wheelchair, R3 was saying no!, no! to R4. V4 said that was all that she can recall. V4 confirmed R4 has history of physical aggression towards others. V4 said when a resident hit another resident that is abuse. V4's signed statement dated 11/6/24 show I witnessed both residents arguing, over the chair (R3's wheelchair) R4 was wanting R3's wheelchair that she was using- she said no but he (R4) tried to push the chair swinging his arms and touched her face. I separated both residents, R4's hospital records dated 11/4/24 show, The patient (R4) is a 79 y/o who has significant dementia and does not talk, . had physical aggression and hit someone at the SNF (skilled Nursing Facility). Apparently, he always have aggressive behavior, Patients family had refused medications. He is over here for clearance so he can start on medications. On 11/4/24 at 11:30AM, both V1 (Administrator) and V2 (Director of Nursing) said due to R4's aggressive behavior towards R3, the family now had agreed to medicate R4's physical aggressions. The facility facility on Abuse dated 10/24/22 show, Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This includes but is not limited to corporal punishment, involuntary seclusion and any physical and chemical restraints not required to treat the residents medical symptoms. Physical Abuse-is the infliction of injury on a resident that occurs other than by accidental means and that require medical attention. Physical Abuse including hitting, slapping, pinching, kicking and controlling behavior through corporal punishment.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 22499 Based on interview and record review the facility failed to return a resident's personal belongings after discharge from the facility for 1 of 3 residents (R1) reviewed for misappropriation of property in the sample of 9 . The findings include: R1's EMR (Electronic Medical Record) shows that R1 discharged from the facility on 10/10/24 after calling 911 for himself, going to the hospital and being admitted to another facility. On 12/20/24 at 9:45 AM V5 (Social Service Director) stated, He went to another facility and I think he has transferred to another facility since then. Someone came from the other facility and picked up his mail and a store brand box (mail item.) He has called several times about his belongings- everything we had was in my office and that was just his mail. The only thing I know he had in his room was a lot of books. He had different shirts on while he was here so I know he had clothes. He was given the opportunity to come pick up his stuff. I had several phone calls with him and would say he is coming on Tuesday and then it would be Thursday. I even called (Social Service Agency) because they had some involvement with him while he was here. I got a call from the police on Monday because he called the police about his stuff. They said he needs to deal with the facility he is at now to get his belongings. It's been over 2 months now so his stuff has gotten discarded. After so long- usually 30 days, his stuff gets discarded- all we had for him was his mail and someone came and picked that up. On 12/20/24 at 9:55 AM V6 (Housekeeping Supervisor) stated, The stuff we had - after 30 days we throw it away. I never had any conversations with (R1). He had like 3 big boxes of books and we discarded them in mid November. On 12/20/24 at 11:05 AM, V1 (Administrator) stated, We found 2 boxes of his stuff (just now) and I called him- so as soon as he calls me back I will let you know. There is some crayons and papers and stuff in the box- I didn't want to go through all of his stuff. But I called him and let him know it is here. (Surveyor asked about the 3 boxes of books and his clothes) I don't know about those but we found 2 boxes and I called him and let him know. V1 stated that the facility did not have an inventory list for R1's belongings. The Facility Concern Form dated 12/16/24 (same date as the complaint) states, Resident discharged from the facility in October. Never picked up belongings. Several phone calls about picking up belongings with no follow-through. Informed items needed to be picked up due to unable to store. The resolution states, Items he had via mail kept and picked up by new facility. Resident content with (?). This form also shows the staff involved with this concern as V1, V5 and V6. The facility policy entitled Abuse Policy and Procedure dated 11/15/24 states, Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent.

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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** 34117 Based on interview, record review the facility failed to ensure the prescribed treatment was performed for a resident's surgical wound and failed to ensure medical information was sent with a resident's surgical follow up appointment. This applies to 1 of 3 residents (R2) reviewed for quality of care in the sample of 9. The findings include: R2's face sheet shows he was a [AGE] year old male with diagnoses including orthopedic aftercare following surgical amputation, acute hematogenous osteomyelitis left foot and ankle, cellulitis of left lower limb, complete traumatic amputation of one left toe, type 2 diabetes with foot ulcer, diabetic neuropathy, congestive heart failure, heart disease, dependence of renal dialysis, non-pressure of chronic ulcer of left foot with necrosis of muscle, and occlusion and stenosis of bilateral cardiac arteries. On 12/20/24 at 10:41 AM, V14 (ADON) said residents who are sent out on appointments should be sent with the face sheet, physician orders, and labs. This is the way we communicate care of the resident. R2 was readmitted on [DATE], he had a follow up with his surgeon on 11/14/24. V4 said he received a call from the wound clinic reporting R2 arrived without any paperwork V15 (R2's surgeon) reported there was no paperwork, he was pretty upset. V15 also reported his wound dressing were not being changed. I don't know why he would think that. Nursing should document when the resident leaves for an appointment including paperwork provided. R2's cognition was impaired, he's not able to answer questions and did not have an escort or family present with him for his appointment. V8 (LPN) was R2's nurse that day and she claimed she sent the paperwork, but V15 called and reported there was no paperwork sent. On 12/20/24 at 11:05 AM, V8 (LPN) said she was R2's nurse when he was sent out on his appointment on 11/14/24. There was a concern R2's paperwork was not sent with him to his follow up appointment. V8 reported she gave it the driver, but V15 reported there was no paperwork sent. Maybe the driver did not give it to R2. I don't understand. Paperwork should be sent out including face sheet, medication list, physician orders and labs. On 12/20/24 at 11:11 AM, V7 (Wound Nurse) said treatments should be followed and documented according to the physician's order. R2 had a post surgical left foot wound. V7 said R2 had follow up appointment on 11/14/24 and his dressing was changed prior to his appointment. On 12/20/24 at 2:00 PM, V15 (R2's Surgeon) said R2 arrived at his follow up appointment on 11/14/24, two days after being discharged from the hospital. R2 arrived with no paperwork which is major problem. R2's dressing looked exactly the same as he left the hospital. V15 said he placed R2's dressing on at the hospital. I could tell it was not changed. R2's alginate dressing which is an absorbate turns jelly and clumpy if it's been there too long and that's how his dressing presented. V15 said he spoke with V14 (ADON) regarding R2's dressing and no paperwork sent with him. V14 claimed R2's dressing was changed, but the dressing should not appear in that manner if it was. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2' Treatment Administration Record for November 2024 shows orders collagenase ointment apply application topically daily to left lateral foot post normal saline cleanse with betadine to eschar area and calcium alginate, cover with absorbate and kerlix daily and as needed if soiled or dislodged one time a day to left foot. The TAR shows there was no documentation on 11/13/24, the treatment was performed. R2's After Visit Summary dated 11/14/24 by V15 documents contacted the facility and spoke with V14 (ADON) and informed him patient was dropped off without any documentation of any medical information as well informed him that appears the wound dressing has not been changed since his discharge two days ago. The facility's Wound Prevention and Healing Policy reviewed 2024 states, To provide wound care treatment/services based on evidence -based standards of care under the direction of a physician. The facility's Appointments and Transportation Policy reviewed 2024 states, Prior to the appointment, the staff or designee will gather the necessary paperwork to send the resident to the appointment. This includes, but is not limited to a face sheet, and required documentation from the EMR system .all paperwork should be given to the family or driver for the appointment .