| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145350 | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br><br>B. Wing | (X3) DATE SURVEY COMPLETED<br><br>08/13/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pearl of Rolling Meadows,the | 4225 Kirchoff Road<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>Based on interview and record review the facility failed to notify the local emergency room hospital of a resident's transfer for 1 of 1 resident (R1) reviewed for admission, transfer and discharge. Findings include:On 8/12/2025 at 11:30am V4(Nurse) said that R1 had an unwitnessed fall and was found on the bedroom floor with a pillow under his head, V4 said that R1 is alert and oriented times one and unable to say what happened R1 was assisted to the bed and the nurse practitioner gave orders to send to the local emergency room for an evaluation. V4 said that she gave report to the oncoming nurse of the incident, prepared documents, while R1 was waiting for the ambulance to arrive, V4 said she did not notify the local emergency room hospital of R1 transfer because she did not know when the ambulance would arrive, V6(Nurse) expressed understanding. On 8/12/2025 at 1:00pm V6(Nurse) said that he received report from the ongoing nurse of R1 fall and that R1 is alert but confused and would not be able to say what happened to him. V6 said when the ambulance arrived, he gave documents to the ambulance, and he did not notify the local emergency room of R1 arrival for an evaluation of a fall that is for the ambulance driver to do we don't do that here. On 8/12/2025 at 1:10pm V2 (Director of Nursing-DON) said I expect all nurses to notify the receiving facility of a transfer even if they can advocate for themselves or not, R1 is confused and cannot speak for himself the local emergency room hospital should have been notified.On 8/12/2025 at 1:15pm V1(Administrator) said I expect all nurses to give a full report to the receiving facility of any resident transferring. An admission Record dated 8/12/2025 indicates R1 has a diagnosis of Delirium due to know physiological condition, cognitive functions and abnormalities of the gait and mobility, a care plan dated 8/12/2025 for impaired cognitive function/dementia or impaired thought processes. Facility Policy:Transfer or Discharge, Emergency revised 2/28/2025Policy Statement:Emergency transfers or discharges may be necessary to protect the health and /or well -being of the resident. Procedure:4. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures. b. notifies the receiving facility that the transfer is being made. |

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 |
|---|---|---|

FORM CMS-2567 (02/99)
Previous Versions Obsolete

Event ID:

Facility ID:
145350

If continuation sheet
Page 1 of 1