STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145612	A. Building B. Wing	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Crystal Lake, The	1000 East Brighton Lane Crystal Lake, IL 60012

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 34314 Based on observation, interview and record review the facility failed to ensure staff safely assisted a resident with repositioning in bed. This applies to 1 of 3 residents (R1) reviewed for safety/supervision in the sample of 3. The findings include: On May 28, 2024, at 9:01 AM, R1 was asleep in bed. R1 had two scabs from lacerations in the shape of a V on his forehead. They measured approximately an inch and a half to 2 inches a piece. He also had a scab from another laceration on the top of his head. There were 7 staples that were visible. The laceration measured approximately 10 inches long. R1 was lying on an air mattress. There were no side rails on the bed or anything for R1 to hold on to when he rolled over. R1 was also a very large man. The bed had an extender on it for length because he appeared to be over 6 feet tall. The left side of the bed had a nightstand, and the right side of the bed had a closet. R1's arms were wrapped with a gauze dressing and very swollen with fluid. R1's electronic medical record shows, he is on hospice and bed bound (he has not been out of bed for a few weeks). R1's witnessed fall incident report dated May 23, 2024, shows, Incident description: Nursing description: whilst [SIC (statement is correct)] in another room writer heard CNA (certified nursing assistant) saying not to roll too far. writer went to where CNA wss (was [SIC]) assisting patient. writer observed patient face down on the right side of his bed with his legs on the bed. Resident Description: pt (patient) said he rolled too far. Immediate action take: Description: Patient kept in place on floor d/t (due to) bleeding from head and mouth . Witnesses: V4 CNA. R1's progress notes dated May 23, 2024, shows, At about 450am writer rushed to pt's room after hearing a sound and staff calling for assistance. Upon arrival writer observed pt off his bed face down on the floor while his legs were still on the bed Pt bleeding from mouth, forehead and head . R1's progress notes dated May 23, 2024, shows, Was asked to see Patient's head upon return from ER (emergency room). Patient stated when he was being turned during brief changing by CNA, I helped them too much and went over the side and hit my face and head. 9 staples present . Abrasion to forehead . Small dry laceration to left temple. (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: 145612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2024
NAME OF PROVIDER OR SUPPLIER: Pearl of Crystal Lake, The		STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 East Brighton Lane Crystal Lake, IL 60012	

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's after visit summary from local emergency room visit dated May 23, 2024, shows, Today's Visit: Reason for visit: fall, closed head injury, scalp laceration. Diagnoses: cut on skin on top or back of head, contusion of scalp. On May 28, 2024, at 10:15 AM, V4 CNA stated, she was performing incontinence care with R1. She stated R1, rolled himself over and rolled too far and fell out of bed. She was by herself and not able to catch him because he rolled out of the bed on the opposite side that she was on. She also stated, there are stickers on everyone's bed that shows how they transfer and reposition. She couldn't remember what R1's says. She thought it was for transfers only. R1's sticker on his bed shows he is a 2 person assist with a mechanical lift. V4 CNA's witness statement dated May 23, 2024, shows, I provided care for the resident at 2 AM and 4:50 AM. Once I attempted to clean the resident, I asked to turn so I could clean the bottom and change the brief. Resident continued to turn after I told him to stop. I tried to grab the resident, but he slipped out of my reach and on the floor. NOD (nurse on duty) walked into the room when pt was on the floor. On May 28, 2024, at 10:09 AM, V7 R1's wife stated, the facility called her and told her that one person was changing R1 when he rolled out of bed. She went to the hospital with R1. R1 told her that he thought he was grabbing the armoire and kept going, falling out of bed. He didn't have anything to grab. The girl slid him too much and he kept going. She also stated, R1 was 6 feet 6 inches tall. He is a big, tall guy. On May 28, 2024, at 10:32 AM, V8 hospice Registered Nurse (hospice RN) stated, R1 told her he was being changed and the girl turned him too far and he fell out of bed. He is such a big guy in a small bed. With nothing to hold on to, anyone would fall out. There should have been two people changing him. On May 28, 2024, at 10:48 AM, V9 CNA stated, R1 was a bigger guy and needed two people to reposition him. He is hard to roll and on an air mattress. On May 28, 2024, at 2:40 PM, V10 Wound Care Nurse stated, R1's arms are dead weight and very swollen with edema. He is a big guy. I always need help. She also verified, R1 was on his air mattress when he fell out of bed. R1's weights and vital summary shows, he is 74 inches (6 feet, 2 inches) (R1's wife stated he is 6'6). On May 17, 2024, R1 weighed 231.4 lbs (pounds). R1's Physical Therapy evaluation and plan of treatment dated May 13, 2024, shows, Initial assessment/current level of function and underlying impairments: Current referral: This is an 82 y/o (year old) male patient who was admitted to the hospital due to generalized weakness which impaired patient ability to do safe functional transfers, bed mobility and ambulation using FWW (full wheeled walker) for support. Functional Mobility/Assessment: Bed mobility: roll left and right: substantial/maximal assistance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's care plan shows, The resident is at risk for falls d/t Gait/balance problems. POSITIONING: Staff will check residents' location and activity to ensure if resident is properly and safely positioned in bed or chair/wheelchair. The facility's fall prevention and management policy dated October 29, 2021, shows, Policy statement: The facility is committed to its duty of care to residents and patients in reducing risk, the number and consequences of falls including those resulting in hard and ensuring that a safe patient environment is maintained.