STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145689	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Elk Grove, The	1920 Nerge Road Elk Grove Village, IL 60007

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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 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** 48944 Based on interview and record review, the facility failed to ensure neurological assessments were completed accurately for a resident who fell and hit her head, and failed to complete post-fall documentation and include it in the resident's medical record. This applies to 1 out of 5 (R1) residents reviewed for falls. The finding includes: R1's EMR (Electronic Medical Record) showed an admitted [DATE] with diagnoses including cerebral ischemia, refractory anemia, malignant neoplasm of left breast, secondary neoplasm of the bone marrow, antineoplastic chemotherapy-induced pancytopenia, slurred speech, and weakness. R1's admission Minimum Data Set showed R1 was severely cognitively impaired. R1's admission Fall Assessment risk form dated 6/03/2024 showed R1 was at low risk for falls. On 6/07/2024 at 1:00 PM, V2 (Director of Nursing/DON) said R1 had an unwitnessed fall on 6/04/2024 around 10 PM. V2 said the facility staff notified her after the incident and reported R1 was observed on the floor in her room trying to reach for something. V2 said R1 had sustained a small scratch above her left eye, then at the beginning of the following shift at 11 PM, R1's left eye was swollen with purple discoloration. On 6/07/2024 at 1:50 PM, V7 (Certified Nurse Assistant) said she believed she was the aide assigned to R1 on 6/04/2024 evening shift and she was informed after the incident at the end of the shift that R1 had fallen. On 6/11/2024, V21 (CNA) said that instead, she was the aide assigned to R1 on 6/04/2024 on the evening shift. V21 said she heard R1 calling for assistance around 10 PM and R1 was on the bathroom floor on her left side. V21 said V13 (Registered Nurse/RN) went to assess R1. On 6/11/2024 at 10:24 AM, V13 (RN) said she was not assigned to R1, but assisted and assessed R1 after the fall incident around 10:15 PM. V13 said R1 was on the bathroom floor on her left side and had a small cut with slight bleeding on her left eye and a few minutes later it was a larger red bump. V13 said she then notified V12 (Agency RN who was assigned to R1) and instructed her on the facility's post-fall process. V13's June 4, 2024 progress note from10:40 PM showed Patient was observed sitting on the floor in the bathroom patient states she went to use the toilet and when she got up she lost balance and fell hitting her left temporal area against the wall and sustained a small bump on the side of her left eyebrow with slight bleeding . (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/2024 at 12:52 PM, V12 said it was her first time working at the facility, and she was assigned to R1 on 6/04/2024. V12 said around 9-10 PM, V21 (CNA) reported to her R1 had fallen and she went to assess R1. V12 said R1 had a scratch on her left eyebrow with no bleeding. V12 said she believed R1 fell near her bed trying to reach for something. R1's June 4, 2024 progress note from 11:19 PM (written by V12) showed Observed patient on floor. She was trying to reach for something .she has a slight scratch near eye brow. V12 (Agency RN) said V13 (RN) was assisting her with R1's post-fall documentation. There was no further nursing documentation regarding R1's post-fall monitoring. On 6/07/2024 at 4:10 PM, V9 (RN) said he took care of R1 on 6/04/2024 night shift; V9 said he only documented on R1's neurological flow sheet. On 6/07/2024 at 4:20 PM, V14 (RN) said she took care of R1 on 6/05/2024 night shift; V14 said she did not complete R1's post-fall documentation for her shift because R1 was transferred to the hospital. On 6/11/2024 at 11:25 AM, V3 (RN) said she was assigned to R1 on 6/05/2024 morning shift; V3 said she only documented on R1's neurological flow sheet but she forgot to complete the post-fall assessment documentation for her shift. V9, V14, and V3 said R1 remained confused after the fall incident, same as per her baseline orientation. R1's 72 Hour Neurological Flow Sheet showed R1's neurological assessment was started on 6/04/2024 at 10:30 PM and continued until 6/05/2024 at 10:00 PM. The assessment showed throughout that R1's orientation was 1A. Under Orientation in the legend at the bottom of the page, 1 stands for oriented, and 1A indicates the resident is oriented to time, place, and person. For every entry under Pupil, the letter B was written. The legend shows Pupil Response choices as A. Non-PERLA or B. PERLA (with the E in PERLA noting pupils are equal in size). R1's ambulance run report showed the crew was dispatched to the facility at 3:26 AM on June 6, 2024. Under Patient Condition, the report showed R1's primary symptom was altered mental status with a six-hour duration. Under Narrative, the report showed .patient was last normal and talking around 22:00 [10:00 PM]. Nurses state [R1] fell yesterday and was not transported to the hospital. Patient has a large black eye on her left eye which was swollen shut . The report showed R1 was transported to the local hospital. In the Eye Symptoms section in the Assessment Review portion of R1's June 6, 2024 emergency room Nursing Assessment Form from 4:00 AM, a narrative comment showed [Patient] had fall at [nursing home] yesterday (not treated) left eye black, swollen, shut. On 6/13/2024 at 11:50 AM (during the survey and nine days after R1's fall), V2 (DON) said on 6/07/2024, she interviewed staff regarding R1's fall and that she was still getting additional statements. V2 said she had clarified that V7 (CNA) was not assigned R1 on 6/04/2024. V2 said she believed R1 was found on the floor close to her bathroom. V2 said she was unable to locate R1's EMR post-fall event form, post-fall risk assessment, or post-fall follow-up documentation forms per the facility's post-fall process. R1's EMR showed a Follow-up Documentation Falls form dated 6/05/2024 at 10:05 PM showing R1 had bruising to her left eye following the fall event. R1's EMR did not show any additional Follow-up Documentation Fall forms completed. V2 also said she reviewed R1's neurological flow sheet and R1's orientation seemed incorrect based on R1's known baseline orientation. V2 said if neurological assessments were inaccurate, staff could miss a potential significant neurological change. V2 said nurses were expected to follow the facility's fall policy and complete post-fall documentation. R1's EMR did not show a fall assessment risk form after R1's fall incident. R1's care plan was reviewed on 6/07/2024 and did not show any fall intervention for R1's fall incident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's unwitnessed fall incident on 6/04/2024 from 10:24 PM (completed by V12, Agency RN) showed R1 was observed on the floor in her room trying to reach for something and slipped. The report showed Patient is stable with small scratch on left eyebrow and listed R1 as oriented to person, place, and time, and that the document was not part of the medical Record. The facility's Fall Prevention and Management policy (reviewed 12/05/2023) showed Policy Statement: 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 harm . Procedure: 1. Fall Risk Screening .b. Fall risk screening will be used following a fall . The policy showed 3. Procedure for Post-Fall Management a. Post Fall Observation will be completed; b. Perform verbal assessment to the cause of the fall and potential for injury; c. iv. Neurological assessment as indicated g. Nurse with knowledge of the event will document pertinent facts in the medical record. Other staff will be interviewed and or a written witness statement will be completed. Under Section 4 Fall Response, the policy showed 1. Evaluate and monitor resident for 72 hours after the fall. 2. Investigate fall circumstances. Initiate Risk Management/Fall Event .c. Time d. Location .f. Likely cause . h. Staff present . The policy continued 3. Record circumstances, resident outcome and staff response .6. Complete falls assessment and post fall documentation 7. Develop plan of care. 8. Monitor staff compliance and resident response. Section 5 of the policy showed Procedure for fall with potential head injury Falls where patients/residents may have sustained a head injury .will be assessed for neurological check 6. Development of Plan of Care .c. Development of the fall interventions plan is based on results of the Falls Assessment as well as investigation of all circumstances and related resident outcomes .

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944 Based on observation, interview, and record review the facility failed to monitor a resident's weight, assess the resident's nutritional status, and assist the resident with eating to prevent significant weight loss. This failure resulted in R1 experiencing a weight loss of 11.5% in one month. This applies to 1 out of 3 residents (R11) reviewed for nutrition. The finding includes: R11's EMR (Electronic Medical Record) showed an admitted [DATE] with multiple diagnoses including metabolic encephalopathy, facial weakness, pneumonia, acute kidney failure, dysphagia, vitamin B12 deficiency anemia, assistance with personal care, pressure ulcer, delirium, dementia, and depression. R11's MDS (Minimum Data Set) dated 5/15/2024 showed R11 was cognitively impaired and required moderate assistance with eating. On 6/12/2024 at 12:34 PM, R11 was in bed sleeping, he appeared thin with dry skin. Then at 1:40 PM R11 was awake and said he was hungry. R11 started to fidget and lean on his right side trying to reach for a cup of water on his bedside table. V27 (Registered Nurse/RN) was alerted and came to assess R11. R11 yelled, I need food, I did not eat. Then V28 (Certified Nurse Assistant/CNA) said R11 had refused breakfast and lunch, and he had been pocketing and spitting his food earlier in the week. Then at 1:50 PM V28 brought R11 two cups of nutritional supplement drinks and proceeded to assist R11. R11 was shaky and sipped one entire cup and did not want to let go of the cup; then V28 continued to assist R11 with the second cup. V27 (RN) said R11 appeared hungry, and staff should have gotten R11 something else if he had refused his meal. On 6/13/2024 at 9:08 AM, V28 (CNA) said she was familiar with R11 and for approximately a week he had been taking a few bites and then spitting them out and his oral intake would vary every meal. V28 said she had been offering R11 different foods and giving nutritional supplement drinks. R11's nutrition care plan was reviewed on 6/12/2024 and showed R11 was overweight. The care plan was updated on 4/29/2024 and showed Current weight shows 3 lb increase in 1 month. The care plan included an intervention to assist at meals as needed/tolerated and obtain weights on [R11], as per orders and monitor per protocol. Notify of any sign weight changes. R11's rehospitalization discharge documents dated 4/29/2024 showed R11 should have received a high calorie and high protein diet, be offered 2 liters of water orally daily, and continue with an oral nutritional frozen supplement dessert twice daily. R11's Medication Review Report dated 6/12/2024 showed a diet order for general diet mechanical soft texture with regular thin consistency and liquid protein for wound healing. The report did not show R11's discharge hospitalization dietary recommendations or weight monitoring orders. R11's EMR showed the following weights: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	2/18/2024-202.8 lbs. (Pounds) at the hospital 3/15/2024-203 lbs. at admission 3/16/2024-203 lbs. 4/03/2024-204.5 lbs. 4/24/2024-165.2 lbs. at the hospital 4/29/2024-205.6 lbs. at readmission 4/30/2024-206 lbs. 5/14/2024-167.8 lbs. 6/12/2024-148.4 lbs. On 6/12/2024 at 2:48 PM, V2 (Director of Nursing/DON) said resident weights are monitored weekly for four weeks during admissions and readmissions and then monthly or as ordered. V2 said weight discrepancies should be assessed and residents should be reweighed. V2 said identified weight loss should be referred to the dietician for evaluation. V2 said residents who need assistance with feeding should be fed to meet their nutritional needs. On 6/13/2024 at 10:06 AM, V19 (Registered Dietician Consultant) said R11's readmission nutritional assessment was done based on his weight on 4/30/2024. V19 said she was not notified of R11's identified significant weight loss on 5/14/2024. V19 said R11's medical condition had changed from his admission, and she had reassessed his nutritional needs. V19 said R11 was now started on a high-calorie drink of 120 ml (milliliters) three times a day, gelato frozen supplement dessert with lunch, and pudding with dinner for additional calories. V19 continued to say part of R11's significant weight loss could have been avoided if his weight had been monitored and communicated correctly. On 6/14/2024 at 11:42 AM, V31 (Physician) said she was notified on 6/12/2024 of R11's weights and believed R11's weight from 3/15/2024 was a discrepancy. V31 continued to say R11's significant weight loss from 5/14/2024 to present could have been intervened if caught earlier. V31 said she expected the facility to follow its weight policy protocol to assess residents' nutrition. The facility's policy titled Weight with the reviewed date of 7/14/2023 showed General: To establish a policy for the consistent, timely monitoring and reporting of resident weights Guideline: 1. All residents will be weighed on admission, readmission, weekly for the first 4 weeks and then at least monthly. 2. Weekly weights will also be done with a significant change of condition, food intake decline that has persisted for more than one week, or with a physician order .4. The DON or designee to determine a list of reweighs will review all weights upon completion. 5. Once the reweighs have occurred any resident with an unexplained significant or insidious weight loss will have a weight loss investigation . The facility's policy titled Medication Pass Supplementation Program with the reviewed date of 10/30/2023 showed Guideline: 1. Based on the nutritional assessment the Registered Dietician, Health Care Provider or staff nurse may recommend a calorie dense supplement at med pass. 2. The nurse .will ask for an order. The order will include the amount and frequency of the supplement .