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	07/11/2024

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

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** 40054 Based on record review and interview, the facility failed to ensure two staff assisted a dependent resident while providing incontinent care. This failure resulted in R2 falling from the bed to the floor, sustaining a left eye laceration along her hairline. This applies to 1 of 4 residents (R2) reviewed for falls and accidents in a sample of 9. Findings include: V3's (Registered Nurse) witness statement dated 06/23/2024 showed R2 falling on the floor while V4 (Certified Nursing Assistant) was providing incontinent care. R1's Minimum Data Set, dated dated dated [DATE] showed R2 was dependent on most of the activities of daily living, including toileting, hygiene, and rolling left to right, and required two or more assistance to provide incontinent care. The hospital emergency physician progress notes on 06/23/2024 showed R2 fell out of bed with multiple lacerations to the head; CT (Computed Tomography) of the head revealed subdural hematoma, and R2 was admitted for further management to ICU (Intensive Care Unit) V4's incident witness statement dated 06/23/2024 showed he was changing R2 and rolling her to her side. V4 thought R2 attempted to grab the tray or table for stability, which slid away, and R2 lost her balance and fell . A review of the post-fall huddle worksheet showed one Certified Nursing Assistant (V4) was changing R2, and R2 was on her side and left the left side of her bed; the resident appeared to have hit her head on the table and had two lacerations, one on the hair line and other one was on the left eyebrow. On 07/10/2024 at 11:05 AM, V4 (Certified Nursing Assistant) said that on the day of the incident, R2 was soiled, and everyone was busy. V4 said she thought she could help R2 by herself; however, dependent residents need two staff members' assistance, and if she had taken the help of another staff member, she could have probably prevented the fall. On 07/09/2024 at 3:00 PM, V12 (Physical Therapist) said dependent residents should always have at least two staff members assist with bed mobility and incontinent care to prevent falls and injuries. (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
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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 - Actual harm Residents Affected - Few	On 07/09/2024 at 12/12/2023 at 11:22 AM, R2 was in bed and was not interviewable. A review of the face sheet showed that R1 was a [AGE] year-old initially admitted on [DATE] with diagnoses including polyarthritis, fall, long-term use of blood thinner, contusion (discoloration) of the left upper arm, heart diseases with a pacemaker, type 2 diabetes, and chronic kidney disease. On 07/09/2024 between 2:38 PM and 3:00 PM, V5 and V6 (Registered Nurses) and V11 (Certified Nursing Assistant) said dependent or bedbound residents' care should be provided with two assists. V11 said R2 always required two assists for incontinent care and mobility. V11 said when he came to work on the morning of the R2's incident and transferred to the hospital, some staff told him that R2 had a fall while changing with one assist while R2 was holding the bedside table, which slid, and R2 lost her balance and rolled down to floor from the bed. On 07/09/2024 at 2:00 PM, V1 (Administrator) said she thought R2 was with one assist for incontinent care and bed mobility but realized R2 was with two assists after reviewing R2's MDS (Minimum Data Set) documents. She said a dependent resident should have two assistants for activities of daily living care to prevent accidents. V1 said the facility follows universal fall prevention precautions. V1 said R2's fall incidents with injuries were reported to IDPH. A review of the facility's fall prevention and management policy, dated October 2021, showed, in part, that all residents and patients considered at risk for falling regardless of fall risk score. Universal fall precaution (Facility protocol) interventions will be implemented to all. High-risk residents for falls will receive individualized intervention as appropriate to risk factors.