

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145689	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/10/2024
NAME OF PROVIDER OR SUPPLIER  Pearl of Elk Grove, The		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33760</p> <p>Based on interview and record review, the facility failed to ensure a resident was permitted to return to the facility following a behavioral hospitalization for 1 of 3 residents (R2) reviewed for involuntary discharge in the sample of 3.</p> <p>The findings include:</p> <p>R2's electronic medical record accessed on 8/9/24 show R2 was admitted to the facility on [DATE]. R2's diagnoses include Alzheimer disease, schizoaffective disorder, diabetes and cognitive communication deficits.</p> <p>R2's facility assessment dated [DATE] show R2 has moderately impaired cognition.</p> <p>R2's progress notes dated 7/15/24 show R2 was sent out to the emergency room due to aggressive behaviors towards staff via involuntary petition. Daughter was informed</p> <p>A progress notes dated 7/16/24 show R2 was transferred to a behavioral health (in Indiana)</p> <p>A progress noted dated 7/23/24 by V7 (Social Services) show V8 (R2's daughter) reports that the hospital behavioral health is ready to discharge R2. Writer advised daughter to contact social worker at the (facility) to discuss.</p> <p>On 8/9/24 at 1:47 PM, V7 (Social Service) said he was not assigned to R2 so when V8 called the facility that R2 was now ready to be sent back, he told V8 to call back since he was not aware of R2's case.</p> <p>On 8/9/24 at 9 AM. (V8) R2's daughter said the facility refused to take R2 back to the facility after R2 was hospitalized due to his behaviors. V8 said the facility did not give her prior notice. V8 said when the Behavioral Health Hospital located in Indiana informed her that R2 was ready to be discharged , she called the facility but when they found out it was me they would hang up. I was getting the round around, If someone answers the phone, I would be put on hold for a long time or told to call back. I kept calling until I finally got hold of the Admission staff (V5). She informed me that per the Administrator, they will not take my dad back due to his aggressiveness to staff. I reminded V5 that she was well aware of my dad's behavior when he was accepted as your patient from day one.</p> <p>(continued on next page)</p>

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
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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2 was at an Assisted Living but due to his dementia, R2 needed to be moved to a Dementia Unit. V8 said when she did a walk thru at the facility with V5 Admission staff prior to R2 being admitted to the facility last 6/24, she told V5 again that R2 wanders, hard to be redirected, R2 has behaviors of being aggressive. V5 assured V8 that they can handle R2's behavior, that they had a dementia locked unit, staff were trained how to handle dementia patients and had psych Nurse available when needed. V8 said due to R2's behavior he was sent to the hospital then transferred to a Behavioral Unit in Indiana for medications adjustment- cocktail V8 said she was told by the hospital staff that if R2 has the right medications, it can stabilize his behavior. V8 said R2 was now being discharged , it meant R2 was now stable V8 said she wanted R2 to go back to Illinois and does not know how to go about this now, no one was assisting her with this.</p> <p>On 8/9/24 at 12:45 PM V5 (Admission) said during one of the morning meetings, it was discussed that R2 would not be accepted back to the facility due to his behaviors. V5 said she did not notify R2's daughter of the decision until the daughter herself called the facility.</p> <p>On 8/9/24 at 8:50 AM V1 (Administrator) said she refused for (R2) to be readmitted to the facility after R2 was sent to the hospital for evaluation due to behaviors. From the hospital, R2 was sent to a psych unit in Indiana. V1 said V8 (R2's daughter) was not provided notice of the facility decision. The facility did not provide R2 or his family (V8) with a discharge or transfer notice when R2 was sent to the hospital. When asked if staff had spoken to the Behavioral Unit for update on R2's behavior improvement and V1 said she did not asked for R2's update as they were not accepting R2 to return to the facility.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33760</p> <p>Based on interview and record review the facility failed to provide incontinence care to a resident who is dependent on staff for activities of daily living (ADL's) to 1 of 3 residents (R1) reviewed for ADLs in the sample of 4.</p> <p>The findings include:</p> <p>R1's facility assessment dated [DATE] show R1 has no cognitive impairment. The same assessment show R1 is dependent on staff for toileting and R1 is always incontinent for bladder functions.</p> <p>On 8/9/24 at 9:45 AM, R1 was in bed alert and pleasant R1 said, an agency CNA (Certified Nursing Assistant) was assigned to him on day shift last 8/2/24 and 8/3/24. R2 1 said he did not get changed. R1 said last 7/31/24 on PM shift, he again had an agency CNA and he waited long to be changed. R1 said he had to sit on a wet diaper. R1 said he has some redness on his bottom that is why he wanted to be changed sooner. R1 said he already reported his concerns to V2 (Director of Nursing-DON.) that he did not get the care he needed on those three days.</p> <p>On 8/9/24 at 10:10 AM, V2 (DON) said he had spoken to R1 and had DNR (do not return) those agency staff that did not provide incontinence care to R1.</p> <p>A grievance log dated 8/3/24 regarding R1 show R1 not changed in a timely manner by CNA. With resolution that show, (R1) was spoken to on 8/5/24 addressed concern with CNA from agency and was DNR'd.</p> <p>Another grievance for R1 dated 7/1/24 show R1 was not provided timely care with ADLs. Resolution: that the agency provider will no longer return.</p> <p>The facility policy entitled Activity of Daily Living show, Residents will (be) provided with care, treatments and services as appropriate to maintain or improve their ability to carry out activities of ADLs.</p>		