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	09/26/2024

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on interview and record review, the facility failed to protect a resident's right to be free from sexual abuse by a resident with known sexual behaviors and public displays of affection. This failure resulted in R2, a [AGE] year old male resident exposing his genitals to R1, a [AGE] year old female resident and attempting to insert his penis into R1's mouth. R1 has severe cognitive impairment and is unable to consent to sexual relations. This failure resulted in immediate jeopardy when the facility lacked interventions and processes to protect female residents from a resident with known sexual behaviors. The immediate jeopardy began on August 6, 2024 when R2 was moved from a secure Dementia Unit after allegedly kissing and hugging R3. R2's new room was located directly next to R1. No interventions were put in place to ensure other female residents were protected from R2 after moving R2's room. V1 (Administrator) was notified of the Immediate Jeopardy on September 24, 2024 at 11:44 AM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on September 25, 2024 at 1:48 PM, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. This applies to 1 of 5 residents (R1) reviewed for resident-to-resident sexual assault in the sample of 5. The findings include: (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:	(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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On September 18, 2024 at 1:39 PM, and on September 23, 2024 at 2:09 PM, V3 (CNA-Certified Nursing Assistant) said on September 10, 2024 she was walking up and down the corridor, picking up dinner trays. V3 noticed R2 was out of his room. V3 said she approached R1's room and the privacy curtain was closed. V3 said she was surprised by this because the staff never leave R1's privacy curtain closed when they are not in the room because R1 is a high fall risk and requires frequent observation. V3 said she went to pull the privacy curtain back and found R2 standing at R1's bedside with one knee on R1's bed. R2's khaki shorts and belt were down around R2's ankles. V3 could see R2's bare buttocks. V3 continued to say R2 had one hand behind R1's head, and his other hand on his penis, and was trying to put his penis in R1's mouth. V3 said she screamed What are you doing? very loudly and R2 let go of R1 and started to walk back to his room, which was located next to R1's room, with his pants around his ankles. V3 said as R2 shuffled back to his room, his pants remained around his ankles and his belt buckle was clattering on the floor and could be heard as he walked. V3 continued to say she reported the same information to V1 (Administrator) on September 10, 2024. The local police department's report dated September 10, 2024 shows V3 (CNA) provided the same statement to the responding police officer. The EMR (Electronic Medical Record) shows R1 is a [AGE] year old female resident admitted to the facility on [DATE]. R1 has multiple diagnoses including, pelvis fracture, falls, gastrostomy tube, dysphagia, reduced mobility, spinal stenosis, dementia, schizophrenia, generalized anxiety disorder, and fracture of the fifth lumbar vertebra and sacrum. R1's MDS (Minimum Data Set) dated July 30, 2024 shows R1 has severe cognitive impairment, requires setup assistance with eating, is dependent on facility staff for bed mobility and transfers between surfaces, and requires substantial/maximal assistance with all other ADLs (Activities of Daily Living). R1 is always incontinent of bowel and bladder. On September 19, 2024 at 8:41 AM, R1 was sitting at the nurse's station playing a card game with staff and was not able to be interviewed at that time due to the lack of privacy. On September 19, 2024 at 11:30 AM, R1 was sitting at the nurse's station in a wheelchair, sleeping. On September 19, 2024 at 1:38 PM, R1 was lying in bed in her room. R1 was not able to answer questions regarding the incident due to her cognitive status. On September 23, 2024 at 10:21 AM, V8 (Physician) said, [R1] has very advanced dementia. She cannot consent to sex. You cannot even hold a meaningful conversation with her. The EMR shows R2 is a [AGE] year old male resident, admitted to the facility on [DATE]. R2 has multiple diagnoses including, Parkinson's Disease, dementia with behaviors, anxiety, falls, psychotic disorder with delusions, insomnia, and depression. R2's MDS dated [DATE] shows R2 is cognitively intact, requires setup assistance with eating, supervision with oral hygiene, partial/moderate assistance with personal hygiene, bed mobility, and transfers between surfaces, substantial/maximal assistance with toilet hygiene, showers, and lower body dressing, and is occasionally incontinent of bowel and bladder. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's care plan initiated May 9, 2024 shows, [R2] exhibits inappropriate or overly friendly behavioral symptoms including touching staff members and himself while receiving care and making unwanted contact (hugging) and gestures (blowing kisses towards others. He has also entered the rooms of other residents. He lacks insight, reasoning and judgement related to his medical needs. He responds to staff redirection. Multiple interventions initiated May 9, 2024 include, Communicate assertively that resident exercise control over impulses and behavior, intervene and re-direct when any inappropriate behavior is observed, refer for psychiatric evaluation and utilize psychoactive medications as warranted, remind resident to refrain from hostile remarks and inappropriate touching. The facility does not have documentation to show new interventions were initiated until September 17, 2024. On September 19, 2024 at 8:45 AM, R2 was sitting in his room. V4 (RN-Registered Nurse) was present in the room and a one-to-one sitter was sitting at a table outside of R2's room. V4 said R2 is able to walk without assistance or an assistive device. V4 continued to say a one-to-one sitter was present because R2 kept going in and out of other resident's rooms, and because R2 had inappropriate sexual behaviors. V4 left the room and the interview with R2 continued. R2 said he has had Parkinson's disease since 2011. R2 did not have a noticeable tremor when doing purposeful movements during the interview, including reaching for cups of water and juice on his bedside table, drinking, or when walking in his room. R2 did have a quiet vocal tone, and occasionally stuttered. R2 said he was hospitalized in June 2023 at a psychiatric hospital for mental problems. R2 continued to say one of the medications he takes causes excessive behaviors such as gambling, sexual feelings, and the need to masturbate. R2 spelled out the name of the medication as pramipexole. R2 said he frequently has hallucinations. R2 continued to say on September 10, 2024, he was in his room and his room was feeling, Too tiny, too closed in. That bothers me and makes me anxious. I know I am supposed to just suck it up, but sometimes I cannot. I went in [R1's] room and she was lying in bed. I sat on the end of her bed, right next to the board on the end of the bed (resident motions to footboard on his own bed). [R1] was intensely screaming and I wanted to help her. I thought maybe we could chit chat. She asked me if I was the cook, so I knew she didn't have it all upstairs, if you know what I mean. R2 continued to say his pants were falling down due to being uneven because his sister had not sewn his pants correctly. R2 said his pants were falling off and his penis was exposed. The EMR shows multiple documentations regarding R2 including: May 9, 2024 at 4:14 PM, [R2] received a scheduled shower after lunch. CNA reported inappropriate behavior that happened during assisting resident. CNA reported resident touched her lower back. CNA turned and asked him to remove his hand. Resident removed his hand. Resident turned and touched his front perineal area along with masturbation. May 17, 2024 at 1:30 PM, [R2] was observed taking pictures of residents in shared areas and was told to refrain from doing so in the future. The facility's final report to IDPH (Illinois Department of Public Health), received on August 10, 2024 shows on August 5, 2024, [R3] reported that a male resident (R2) made her feel uncomfortable by giving her a hug and a kiss on the cheek because she is married. On August 6, 2024 at 8:42 AM, V13 (NP) documented, [AGE] year old male at [facility] being seen today for hypersexual behaviors. Patient attempting to kiss other residents. He stated he has his reasons why he was doing so. He would not disclose to me. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On August 6, 2024 at 5:20 PM, V7 (SSC-Social Service Coordinator) documented, Writer met with [R2] on nursing unit to discuss room change. Writer explained to patient that he is more appropriately placed on a different nursing unit as he does not directly benefit from the style of dementia-focused activities . He strongly feels that his (self-described) inappropriate behavior on Monday evening is the result of a change to his [pramipexole] dosage. Discussed with guardian and per her request, patient's sister (V33). [V33] recounted patient's history of hypersexual behaviors and expressed understanding as to why relocation may be beneficial for resident. Guardian is also agreeable to room change. Patient ultimately consent to the room change and nursing staff began assisting with relocation to [room close to R1]. On September 16, 2024, V2 (DON) documented a late entry effective September 10, 2024 at 5:15 PM. V2 documented, Received report that resident was observed in another resident's room and appeared partially exposed. On September 11, 2024 at 6:40 AM, V8 (Physician) documented, I was paged by the DON that yesterday [R2] had an episode of hypersexual behaviors. It was reported that yesterday he was found by the CNA in a female resident's room and partially undressed exposing his genitalia to her. The other resident did not come in contact with him, she was sitting on the edge of her bed, according to social services report. In regard to witness's report that patient was partially unclothed, patient notes that he was wearing a pair of shorts which are uneven and have a tendency to sag down but denies any other activities taking place.Patient was seen and examined today. When asked about the incident patient states he was probably behaving inappropriately due to his Parkinson's medications. Patient denies any hypersexual behavior in the past. He ambulates around the facility without an assistive device. A&P (Assessment and Plan): Hypersexual behaviors - discussed in detail with the DON, social services, CNA, and the patient. Refer to psychiatry for psychosis. Refer to neurology for possible change in Parkinson's medications due to possible side effect of hypersexual behaviors, 1-to-1 babysitter advised until further notice. Patient's room changed - advised no shared rooms with other residents. The facility's final report to IDPH (Illinois Department of Public Health) dated September 17, 2024 shows, reported R1 and R2 were in a room. R2 appeared partially undressed. Separated immediately. Abuse cannot be substantiated based on information and facts gathered . On September 19, 2024 at 10:39 AM, V2 (DON-Director of Nursing) said, [V10] (LPN-Licensed Practical Nurse) reported that [R2] was in [R1's] room, which were next to each other. [V3] (CNA) had cared for [R2] all day. They observed [R2] at the bedside of [R1] and [R2's] pants were sagging down. [V3] reported [R2] had his hand on his penis, and his other hand was behind [R1's] head. [R2's] room was moved on August 6, 2024. He was in the Dementia Unit, so he was moved to separate him from [R3]. It was reported he attempted to hug and kiss [R3]. We had psych see him and we made some changes to his pramipexole medication. We were hoping the medication adjustment would help. V2 could not say what other interventions were put in place to protect female residents from R2 after he was moved from the Dementia Unit on August 6, 2024. On September 23, 2024 at 2:09 PM, V32 (CNA) said she had worked the day shift on September 10, 2024 from 6:30 AM to 2:30 PM. V32 said she was assigned to the unit where R2 resided, and he had walked down the hall towards her to ask for a cup of ice. V32 said R2 was wearing khaki pants and a belt. V32 said she did not see R2's pants falling down at any time during her shift, and R2's pants were not falling down while he was walking down the hall to ask for a cup of ice. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On September 19, 2024 at 3:42 PM, V9 (Psych NP-Nurse Practitioner) said, I see [R2] at least once a month. The nurses called me at home, and it seemed like his sexual behaviors escalated so I put him on Paxil to lower his libido. We are giving him the medication to make him not want to have sex as much and for his anxiety and his mood. I am not sure he is a good candidate to be in that facility. I don't think he was a good candidate to be in a room near a cognitively impaired female resident who cannot give consent. On September 23, 2024 at 11:30 AM, V7 (SSC) said, During a meeting with [V33] (Sister of R2) on August 6, 2024, [V33] said [R2] has a history of misinterpreting signs from women as being flirtatious or inviting. He made inappropriate gestures to women, and this extended to family members. [R2] made sexual comments to his sister-in-law. It was known that hypersexuality was part of his situation. He was referred to psych after the sister said that, and the staff were made aware of the potential behaviors and to be aware. The facility does not have documentation to show interventions were put in place regarding R2's sexual behaviors after the kissing/hugging allegation on August 6, 2024 or with R2's room change to a new unit to protect female residents. The facility's Abuse Prevention Program - Policy, effective November 22, 2017 shows, Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This includes but is not limited to corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms.Definitions: Sexual abuse is non-consensual sexual contact of any type with a resident. The facility presented an abatement plan to remove the immediacy on September 24, 2024 at 5:15 PM. The survey team was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility for revisions. The facility presented an abatement plan to remove the immediacy on September 25, 2024 at 1:48 PM and the survey team accepted the abatement plan on September 25, 2024 at 2:33 PM. The Immediate Jeopardy that began on September 10, 2024, at approximately 6:00 PM was removed on September 25, 2024 at 1:48 PM when the facility took the following actions to remove the immediacy: Social Service Director conducted an audit of all residents with hypersexual behaviors on September 24, 2024. No other male resident was identified during the audit. All female residents were assessed for potential sexual abuse by Social Service Director on September 24, 2024. Care plan review was initiated and completed by September 24, 2024. Policy was developed by Regional Social Service Consultant to address hypersexual behaviors that are not easily redirectable. Facility initiated in-services on facility's abuse program and policies to all shifts immediately after the incident and is on-going. All agency staff will receive the same training before the start of the shift. All staff who are not available at this time due to vacation or leave of absence will also receive with the same training prior to start of shift upon return to work. In-services were provided and are being provided by Administrator, DON, and or Social Service and clinical supervisor. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility Administrator and Social Service developed a process to ensure facility staff caring for a resident with the potential for abusing other residents are educated on specific interventions to prevent abuse and protect all residents. Facility Administrator, DON and Social Service provided in-services on all shifts on the following topics: Facility interventions and processes to ensure every effort will be taken to protect female residents from a resident with known sexual behavior. All direct patient care staff were educated specifically on interventions for R2 to prevent abuse and protect all residents. Management of Sexual Behavior policy. Quality Assurance (QA) plans to monitor facility performance to make sure that the corrective actions are achieved and permanent: Administrator developed and utilized a QA tool to ensure that specific interventions for R2 are implemented by direct patient care staff as noted. This audit will be conducted twice weekly for four weeks. All residents that are high risk for sexual abuse will be observed twice weekly to ensure that they are free from abuse and remains safe while residing in the facility. Administrator will randomly select five residents twice weekly and observations to be completed for four weeks. ADHOC QAPI (Quality Assurance Performance Improvement) was initiated on September 18, 2024, and completed on September 24, 2024 to discuss with QA Committee and Medical Director, Plan of Removal and ensure that all corrective actions and safety measures are consistently implemented.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on interview and record review, the facility failed to follow their policy to conduct a thorough investigation of a sexual abuse allegation. This failure resulted in immediate jeopardy when V3 (CNA-Certified Nursing Assistant) reported to V1 (Administrator) that she observed R2 exposing his genitals to R1 and attempting to insert his penis into R1's mouth. The facility unsubstantiated sexual abuse without interviewing all possible witnesses. The immediate jeopardy began on September 10, 2024 when the facility failed to thoroughly investigate an allegation of sexual abuse. V1 (Administrator) was notified of the Immediate Jeopardy on September 24, 2024 at 11:44 AM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on September 25, 2024 at 1:48 PM, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. This failure has the potential to affect all 148 residents residing in the facility. The findings include: The Facility Data Sheet dated September 19, 2024 shows the facility census as 148 residents. On September 18, 2024 at 1:39 PM, and on September 23, 2024 at 2:09 PM, V3 (CNA) said on September 10, 2024 she was walking up and down the corridor, picking up dinner trays. V3 noticed R2 was out of his room. V3 said she approached R1's room and the privacy curtain was closed. V3 said she was surprised by this because the staff never leave R1's privacy curtain closed when they are not in the room because R1 is a high fall risk and requires frequent observation. V3 said she went to pull the privacy curtain back and found R2 standing at R1's bedside with one knee on R1's bed. R2's khaki shorts and belt were down around R2's ankles. V3 could see R2's bare buttocks. V3 continued to say R2 had one hand behind R1's head, and his other hand on his penis, and was trying to put his penis in R1's mouth. V3 said she screamed What are you doing? very loudly and R2 let go of R1 and started to walk back to his room, which was located next to R1's room, with his pants around his ankles. V3 said as R2 shuffled back to his room, his pants remained around his ankles and his belt buckle was clattering on the floor and could be heard as he walked. V3 continued to say she reported the same information to V1 (Administrator) on September 10, 2024. The facility's final report to IDPH (Illinois Department of Public Health) dated September 17, 2024 shows, reported R1 and R2 were in a room. R2 appeared partially undressed. Separated immediately. Abuse cannot be substantiated based on information and facts gathered . (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On September 19, 2024 at 12:40 PM, V1 (Administrator) said interviews of staff members were done on September 16, 2024, six days after the alleged sexual abuse. V1 said the facility's abuse policy shows interviews with possible witnesses should be conducted as soon as possible. V1 continued to say as soon as possible means the staff should be interviewed right away. V1 also said it did not appear the staff that were present in the facility on September 10, 2024 were interviewed as part of the investigation. V1 said, Interviews with residents and staff were done on September 16, 2024. Maybe we were so overwhelmed about what happened that we didn't interview the people that worked that day. V1 continued to say the allegation of sexual abuse was unsubstantiated based on the facility's investigation. Facility documentation shows V2 (DON-Director of Nursing) obtained statements from V3 (CNA) and V10 (LPN) on September 10, 2024. The statements are typed statements. V3 and V10 did not sign their typed statements. The facility does not have documentation to show any other staff provided statements on September 10, 2024. The staffing schedules for September 10, 2024 were reviewed with V1 (Administrator) and compared to the staff statements obtained on September 16, 2024, for the sexual abuse investigation. None of the staff statements obtained on September 16, 2024 were signed by the staff member being interviewed. The staffing schedules show the following staff were present in the facility on September 10, 2024 between 2:30 PM and 10:30 PM, during the alleged sexual abuse. the facility does not have documentation to show the following staff were asked to provide statements during the abuse investigation, including: CNAs: V15, V16, V17, V18, V19, V20, V21, V22, V23, V23, V25, V26 LPNs (Licensed Practical Nurses): V28, V29 RNs (Registered Nurses): V27, V30, V31 On September 23, 2024 at 2:09 PM, V32 (CNA) said she had worked the day shift on September 10, 2024 from 6:30 AM to 2:30 PM. V32 said she was assigned to the unit where R2 resided, and he had walked down the hall towards her to ask for a cup of ice. V32 said R2 was wearing khaki shorts and a belt. V32 said she did not see R2's shorts falling down at any time during her shift, and R2's shorts were not falling down while he was walking down the hall to ask for a cup of ice. V32 said, as of September 23, 2024, she had not been interviewed regarding R2, including asking what clothes he was wearing that day or if she had seen any type of wardrobe malfunction on September 10, 2024. The EMR (Electronic Medical Record) shows R1 is a [AGE] year old female resident admitted to the facility on [DATE]. R1 has multiple diagnoses including, pelvis fracture, falls, gastrostomy tube, dysphagia, reduced mobility, spinal stenosis, dementia, schizophrenia, generalized anxiety disorder, and fracture of the fifth lumbar vertebra and sacrum. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R1's MDS (Minimum Data Set) dated July 30, 2024 shows R1 has severe cognitive impairment, requires setup assistance with eating, is dependent on facility staff for bed mobility and transfers between surfaces, and requires substantial/maximal assistance with all other ADLs (Activities of Daily Living). R1 is always incontinent of bowel and bladder. The EMR shows R2 is a [AGE] year old male resident, admitted to the facility on [DATE]. R2 has multiple diagnoses including, Parkinson's Disease, dementia with behaviors, anxiety, falls, psychotic disorder with delusions, insomnia, and depression. R2's MDS dated [DATE] shows R2 is cognitively intact, requires setup assistance with eating, supervision with oral hygiene, partial/moderate assistance with personal hygiene, bed mobility, and transfers between surfaces, substantial/maximal assistance with toilet hygiene, showers, and lower body dressing, and is occasionally incontinent of bowel and bladder. The facility's Abuse Prevention Program - Policy, effective November 22, 2017 shows: IV. Investigation: As soon as possible after an allegation of abuse, neglect, mistreatment, misappropriation of resident property, or exploitation, the administrator or designee will initiate an investigation into the allegation which may include the following elements: Interviewing all persons who may have knowledge of the alleged incident, including, but not limited to: All persons who reported the suspicion, allegation or incident, the alleged victim (if the victim is unable to be interviewed, this shall be documented), the alleged perpetrator (if the alleged perpetrator is a resident who cannot be interviewed, this shall be documented), any witnesses or potential witnesses to the alleged occurrence or incident, any staff having contact with the resident during the period of the alleged incidents, roommates, other residents, family or visitors. The facility's Abuse Prevention Program - Toolkit, reviewed 09/05/2024 shows: Investigation Procedures: Regardless of the specific nature of the allegation (physical, sexual, verbal/mental abuse, theft, neglect, unreasonable confinement/involuntary seclusion or exploitation), the investigation shall consist of: Interview of the person(s) reporting the incident, interview of the alleged victim, if interviewable, interview of the alleged perpetrator, interview of the witnesses to the incident, if any, which includes visitors to the facility, interview of staff members having contact with the alleged victim and alleged perpetrator during the period of the alleged incident. Interview Process: Determine if written statements will be taken of the interviewee. If statements are taken, ensure that the statement is factual and not conclusory (i.e., no assumptions, only facts observed or known to the interviewee). Whether handwritten or typed, the statement must be signed and dated. If the interviewee refuses to sign, the interviewer should document that fact on the statement and sign and date the statement themselves. To the extent possible, all interviews should be conducted with another person present for the interview. The facility presented an abatement plan to remove the immediacy on September 24, 2024 at 5:15 PM. The survey team was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility for revisions. The facility presented an abatement plan to remove the immediacy on September 25, 2024 at 1:48 PM and the survey team accepted the abatement plan on September 25, 2024 at 2:33 PM. The Immediate Jeopardy that began on September 10, 2024, at approximately 6:00 PM was removed on September 25, 2024 at 1:48 PM when the facility took the following actions to remove the immediacy: (continued on next page)

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	145689	A. Building B. Wing	09/26/2024

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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	V3 was immediately interviewed regarding the allegation. All staff that were on the schedule on September 10, 2024, the day of the allegation were reinterviewed on September 19, 2024. Law Enforcement report was made on September 10, 2024, Case #EGP24-018160 Facility staff assessed all residents in house with possible similar challenging behaviors to ensure that the safety of individuals is met at all times on September 24, 2024. Facility has reviewed the policy and procedure on investigating abuse allegations on September 24, 2024. Facility completed education with V1 (Administrator) regarding investigating abuse allegations on September 24, 2024 by consultant, [NAME] President of Operations. Facility completed education with V2 (DON) regarding investigating abuse allegations on September 24, 2024 consultant, [NAME] President of Operations. Facility completed education with V12 (Director of Clinical Services) regarding investigating abuse allegations on September 24, 2024, with V11 (CNO-Chief Nursing Officer). Facility completed education with clinical staff regarding investigating abuse allegations on September 17, 2024. Facility created an audit tool to measure thorough investigations of all abuse allegations. Facility Administrator and/or designee will monitor all abuse allegations for appropriateness to include ensuring all possible witnesses or potential witnesses to abuse allegations are interviewed. QA (Quality Assurance) plans to monitor facility performance to make sure that the corrective actions are achieved and permanent: Administrator and/or designee will review audits weekly to ensure compliance with the measures put in place to address thorough investigation of all abuse allegations for four weeks. AD HOC QAPI (Quality Assurance Performance Improvement) was initiated on September 18, 2024 to discuss with QA Committee and Medical Director, Plan of Removal and to ensure that all corrective actions and safety measures are consistently implemented. Ad HOC QAPI was completed and implemented on September 24, 2024.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on interview and record review, the facility failed to update a resident's care plan when a resident exhibited sexual behaviors and public displays of affection and required a room change. This applies to 1 of 5 residents (R2) reviewed for resident-to-resident sexual assault in the sample of 5. The findings include: On September 18, 2024 at 1:39 PM, and on September 23, 2024 at 2:09 PM, V3 (CNA-Certified Nursing Assistant) said on September 10, 2024 she was walking up and down the corridor, picking up dinner trays. V3 noticed R2 was out of his room. V3 said she approached R1's room and the privacy curtain was closed. V3 said she was surprised by this because the staff never leave R1's privacy curtain closed when they are not in the room because R1 is a high fall risk and requires frequent observation. V3 said she went to pull the privacy curtain back and found R2 standing at R1's bedside with one knee on R1's bed. R2's khaki shorts and belt were down around R2's ankles. V3 could see R2's bare buttocks. V3 continued to say R2 had one hand behind R1's head, and his other hand on his penis, and was trying to put his penis in R1's mouth. V3 said she screamed What are you doing? very loudly and R2 let go of R1 and started to walk back to his room, which was located next to R1's room, with his pants around his ankles. V3 said as R2 shuffled back to his room, his pants remained around his ankles and his belt buckle was clattering on the floor and could be heard as he walked. V3 continued to say she reported the same information to V1 (Administrator) on September 10, 2024. The EMR (Electronic Medical Record) shows R2 was admitted to the facility on [DATE]. R2 has multiple diagnoses including, Parkinson's Disease, dementia with behaviors, anxiety, falls, psychotic disorder with delusions, insomnia, and depression. R2's MDS (Minimum Data Set) dated July 24, 2024 shows R2 is cognitively intact, requires setup assistance with eating, supervision with oral hygiene, partial/moderate assistance with personal hygiene, bed mobility, and transfers between surfaces, substantial/maximal assistance with toilet hygiene, showers, and lower body dressing, and is occasionally incontinent of bowel and bladder. R2's care plan initiated May 9, 2024 shows, [R2] exhibits inappropriate or overly friendly behavioral symptoms including touching staff members and himself while receiving care and making unwanted contact (hugging) and gestures (blowing kisses towards others. He has also entered the rooms of other residents. He lacks insight, reasoning and judgement related to his medical needs. He responds to staff redirection. Multiple interventions initiated May 9, 2024 include, Communicate assertively that resident exercise control over impulses and behavior, intervene and re-direct when any inappropriate behavior is observed, refer for psychiatric evaluation and utilize psychoactive medications as warranted, remind resident to refrain from hostile remarks and inappropriate touching. The facility does not have documentation to show new interventions were initiated until September 17, 2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On August 6, 2024 at 8:42 AM, V13 (NP) documented, [AGE] year old male at [facility] being seen today for hypersexual behaviors. Patient attempting to kiss other residents. He stated he has his reasons why he was doing so. He would not disclose to me. On August 6, 2024 at 5:20 PM, V7 (SSC-Social Service Coordinator) documented, Writer met with [R2] on nursing unit to discuss room change. Writer explained to patient that he is more appropriately placed on a different nursing unit as he does not directly benefit from the style of dementia-focused activities . He strongly feels that his (self-described) inappropriate behavior on Monday evening is the result of a change to his [pramipexole] dosage. Discussed with guardian and per her request, patient's sister (V33). [V33] recounted patient's history of hypersexual behaviors and expressed understanding as to why relocation may be beneficial for resident. Guardian is also agreeable to room change. Patient ultimately consent to the room change and nursing staff began assisting with relocation to [room close to R1]. On September 23, 2024 at 11:30 AM, V7 (SSC) said, During a meeting with [V33] (Sister of R2) on August 6, 2024, [V33] said [R2] has a history of misinterpreting signs from women as being flirtatious or inviting. He made inappropriate gestures to women, and this extended to family members. [R2] made sexual comments to his sister-in-law. It was known that hypersexuality was part of his situation. He was referred to psych after the sister said that, and the staff were made aware of the potential behaviors and to be aware. The facility does not have documentation to show interventions were put in place regarding R2's sexual behaviors after the kissing/hugging allegation on August 6, 2024 or with R2's room change to a new unit to protect female residents with dementia. On September 26, 2024 at 4:12 PM, V1 (Administrator) said R2's care plan should have been updated after the hugging/kissing incident on August 6, 2024. The facility's Comprehensive Care Plan Policy, reviewed 12/18/2023 shows, To meet the resident's physical, psychosocial and functional needs, facility will develop and implement a comprehensive, person-centered care plan for each resident that includes measurable objectives and target goals. Procedure: .2. Care plan interventions or approaches will be based on resident or patient health records, comprehensive assessments, resident/patient preferences and reasonable requests from family/legal representative.10. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change. 1 The Interdisciplinary Team must review and update the care plan: When there has been a significant change in the resident's condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay, and at least quarterly, in conjunction with the required quarterly MDS assessment.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on interview and record review, the facility failed to ensure a resident was seen by their attending physician as shown in the facility's policy. This applies to 1 of 5 residents (R2) reviewed for physician visits in the sample of 5. The findings include: The EMR (Electronic Medical Record) shows R2 was admitted to the facility on [DATE]. R2 has multiple diagnoses including, Parkinson's Disease, dementia with behaviors, anxiety, falls, psychotic disorder with delusions, insomnia, and depression. R2's MDS (Minimum Data Set) dated July 24, 2024 shows R2 is cognitively intact, requires setup assistance with eating, supervision with oral hygiene, partial/moderate assistance with personal hygiene, bed mobility, and transfers between surfaces, substantial/maximal assistance with toilet hygiene, showers, and lower body dressing, and is occasionally incontinent of bowel and bladder. The EMR shows V8 (Physician) is R2's primary care physician. On May 23, 2024 at 12:30 PM, V8 (Physician) documented the following late entry note effective April 30, 2024 at 12:29 PM: agree with plan of care, continue current treatment plan therapy notes reviewed, discussed in detail with FNP (Family Nurse Practitioner) [V13] vitals, labs, medications reviewed. As of September 24, 2024, the facility did not have documentation in the EMR to show V8 did a history and physical on R2. The facility does not have documentation to show R2 was seen by V8 (Physician) until September 11, 2024. On September 23, 2024 at 10:36 AM, V8 (Physician) said, We usually see residents every six to eight weeks. He is not an acute patient. I don't know his insurance. I have seen him two or three times since his admission. The NP (Nurse Practitioner) did his initial history and physical. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy entitled MR Physician Visit Policy revised on 5/15/24 shows: Purpose: Each resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least every 60 days thereafter. Must be seen means that the physician must make face-to-face contact with the resident. A complete history and physical must be completed within 72 hours after admission or five days prior. The history and physical must be completed by the physician, labeled H & P and must include a skin assessment. The history and physical cannot be completed by the nurse practitioner or the physician's assistant. A physician visit is considered timely if it occurs no later than 10 days after the date the visit was required. After the initial visit, a qualified nurse practitioner, clinical nurse specialist or physician assistant may make every other required visit. However, the physician must visit resident when the resident's condition makes that visit necessary. If the physician dictates a progress note, a brief note should be entered into the record at the time of the visit stating that dictation will follow. If there has been an acute change in the resident's condition, the physician should write a note for the medical record in addition to the dictated progress note. The dictated progress note should be received by the facility and filed in the medical record within 7 days.