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	06/04/2025

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** Based on interview and record review, the facility failed to protect a resident's (R4) right to be free from sexual abuse by a facility staff member. This failure resulted in R4 experiencing psycho-social harm from V13's (Certified Nursing Assistant/CNA) inappropriate sexual touching. The facility also failed to protect a resident's (R2) right to be free from physical abuse by another resident (R1). This applies to 2 of 6 residents (R2 and R4) reviewed for abuse. The findings include: 1. On 6/03/2025 at 10:00 AM, R4 said V13 (CNA) had sexually touched her private vaginal area with his gloved hand and fingers when rendering incontinence care on the early morning of 6/01/2025. R4 said she told V13 to stop touching her because he was causing her pain in her private area. R4 said V13 would take approximately thirty minutes when providing her incontinence care, which was unusual for her. R4 said V13 had done this to her three times prior when rendering incontinence care. R4 said the prior incidents had occurred in the past months after she no longer had a roommate. R4 said she had not reported the prior incidents because she was afraid but after the last incident on 6/01/2025, she decided to report it to her family because it was painful. R4 said she also did not want this to occur to other residents. R4 said she then decided on 6/02/2025 to be transferred to the hospital for a sexual assault exam. R4 said she was told her exam showed trauma and has decided to pursue criminal charges. On 6/04/2025 at 11:00 AM, R4 said V13's inappropriate sexual contact to her vaginal area made her feel sexually violated. R4 said she had been fearful that V13 would continue to care for her after the incidents. R4 said she now felt safe that V13 was no longer at the facility. On 6/02/2025 at 1:55 PM, V14 (R4's Family Member) said R4 called her on the evening of 6/01/2025 and reported V13 had touched her private area inappropriately when providing incontinence care on four different occasions including on 6/01/2025. V14 said she notified V1 (Administrator) immediately. On 6/02/2025 at 12:40 PM, V17 (Social Worker) said she conducted a well-being check on R4 after being informed of R4's reported incident. V17 said R4 was alert and reviewed her care plan. V17 said R4 had no behaviors or history of reporting abuse. (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

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 6/04/2025 at 10:15 AM, V15 (Hospital Sexual Assault Nurse Examiner/SANE) said she interviewed, recorded a physical assessment, and collected samples from R4 after she went to the hospital for sexual assault treatment. V15 said R4 reported V13 had assaulted her on 6/01/2025 at 3 AM when changing her incontinence brief and had done this three times prior in the past months. V15 said R4 reported V13 touched her vaginal and rectal areas with his gloved fingers causing her discomfort and one time he spit saliva in his hand for lubrication. V15 said R4's vaginal exam showed positive uptake of specialized dye which indicates trauma of abrasions or tears. V15 said she also collected swab samples as part of R4's kit. On 6/04/2025 at 10:50 AM, V16 (Local Police Detective) said he had formally interviewed R4 on 6/02/2025. V16 said R4 wanted to proceed with criminal charges. V16 said the criminal investigation was active and could not provide additional information. On 6/04/2025 at 3:30 PM, V11 (Physician) said on 6/04/2025 he interviewed R4 about her reported incident. V11 said R4 was alert and coherent. V11 said R4's statement about being sexually touched inappropriately by a CNA during incontinence care was consistent. On 6/02/2025 at 5:00 PM, V13 (CNA) was interviewed over the phone. V13 denied R4's allegation. V13 said he on 6/01/2025 he had provided R4 incontinence care at 3 AM and 6 AM. V13 said he had provided care to R4 in the past and believed the last time was weeks prior to 6/01/2025 when she had a roommate. On 6/02/2025 at 11:30 AM, V1 (Administrator) said V14 (R4's Family Member) notified him of R4's sexual abuse allegation involving V13 (CNA) on 6/01/2025. V1 said the facility had initiated an investigation and notified all responsible parties including the local police and V11 (Physician). V1 said V13 was immediately suspended from the building. V1 said R4 had refused to be transferred to the hospital on 6/01/2025 but after talking to V12 (Nurse Practitioner/NP) on 6/02/2025 she agreed. V1 said the facility was reviewing R4's hospital records from 6/01/2025 and communicating with the local police. R4's care plan dated 6/04/2025 had a focus problem initiated on 9/24/2024 for being at risk for abuse and trauma. The care plan said R4 should be observed and monitored to mitigate potential abuse. R4's MDS (Minimal Data Sheet) assessment dated [DATE] showed R4 was cognitively intact. The assessment also said R4 was frequently incontinent of bowel and bladder needing partial to moderate assistance with her toileting hygiene. R4's progress note dated 6/02/2025 said Primary MD by phone about resident reported incident on Saturday night. MD ordered to send resident to hospital ER for evaluation of trauma. V12's (NP) progress note dated 6/02/2025 said RN requested patient be seen for alleged sexual abuse. Pt states that CNA touched her inappropriately Saturday night .Appears to be anxious about events .Provided emotional support. R4's hospital records dated 6/02/2025 said R4 was evaluated and treated for sexual assault. The records said R4 reported V13 touched her inappropriately in her private area with his finger on 6/01/2025 at approximately 3 AM during incontinence care. The record said R4 reported V13 had done this three times prior. The record said R4's vaginal physical exam showed there was positive uptake of toluidine blue dye in five areas. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Census List report dated 6/03/2025 showed R4 last had a roommate on 4/21/2025. The facility's untitled document showing V13's (CNA) residents assignments showed after 4/21/2025 V13 was assigned R4 on 4/28/2025, 5/01/2025, 5/15/2025, 5/21/2025, 5/22/2025, and 5/31/2025 on the overnight shift (10:30 PM-6:30 AM). 2. On 5/31/2025 at 9:55 AM, R1 was being assisted with his care by V4 (CNA). R1 was not able to engage in the interview. V4 said R1 was confused and had aggressive behaviors towards others. V4 said R1 had been aggressive towards R2 on 2/19/2025 and 5/14/2025 in the dining room. V4 said R2 no longer resided in the memory care unit. On 5/31/2025 at 9:45 AM, R2 was in her room. V5 (Registered Nurse/RN) asked R2 about her incident involving R1 in her preferred language. V5 said R2 was confused and unable to recall the incident because of her dementia. On 5/31/2025 at 12:05 PM, V7 (Agency CNA) said on 2/19/2025 she was supervising the memory care unit's dining room. V7 said R2 was trying to leave the area when R1 stood and started hitting R2 on the face and head. V7 said she intervened and then R1 launched and swung at her but did not hit her. V7 said R1 was redirected to his room and placed on 1-on-1 supervision till he was transferred to the hospital. On 5/31/2025 at 11:40 AM, V9 (Licensed Practical Nurse/LPN) said on 5/14/2025 he heard arguing coming from the memory care unit's dining room. V9 said R2 was on the floor and R1 was over her swinging his hands at her. V9 said R1 hit the back of R2's head. V9 said he had difficulty redirecting R1 but was able to separate them. V9 said R1 was transferred to the hospital for his aggressive behavior. V9 said R2 quickly forgot about the incident because of her dementia. On 5/31/2025 at 12:10 PM, V1 (Administrator) said he investigated R1 and R2's incidents on 2/19/2025 and 5/14/2025. V1 said his abuse investigation process included obtaining witness statements from those present to identify the root cause of the incident. V1 said R1 was petitioned out and admitted for aggressive behavior after both incidents. V1 said both R1 and R2 had dementia and believed R2's loud noises triggered R1 to flare his arms. R2's care plan dated 5/31/2025 said she had impaired cognition and was confused related to her dementia. The care plan also said R2 was at risk for abuse and trauma. R2's progress note dated 2/19/2025 said At approximately 1215 pm, a physical altercation occurred between [R2] and [R1] in the dining room. Witnesses reported that the incident started when [R2] became upset because [R1] was in the way when attempting to leave the dining room. She began to yell at [R1] in her native language. This evoked a response from [R1], where he struck [R2] in the head. V7's Statement form dated 2/19/2025 said she observed R1 approaching R2 when she was trying to leave the dining room. The statement continued to say R1 then hit R2 in the head with an open hand approximately twice. R2's progress note dated 5/14/2025 said Resident was found on the floor in the dining area following an altercation with another resident, who was observed hovering over her. V9's Statement form dated 5/14/2025 said he observed R1 hovering over R2 while she was on the floor. The statement continued to say V9 attempted to move R1 but was resistive and started to slap R2 in the head. R1's care plan dated 5/31/2025 said he had impaired cognition and was confused related to his dementia and schizoaffective diagnosis. The care plan said I am confused and disoriented and may misinterpret interactions/situations I experience. Consequently, I may present with aggression when agitated or frustrated. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R1's Petition for Involuntary Judicial admission dated 2/19/2025 said R1 required an emergency inpatient hospital admission because he presented physically aggressive with another resident. The resident is nonredirectable at this time. R1's Petition for Involuntary Judicial admission dated 5/14/2025 said R1 again required an emergency inpatient hospital admission because he presented physically aggressive with another resident. The resident is nonredirectable at this time. The facility's final investigation report for R1 and R2's incident on 2/19/2025 said After review of the incident, contact between residents appears to be an accident R1 was startled by R2 speaking and is best suited in a calm atmosphere away from startling moments. CNAs and nurses educated on techniques of de-escalation and signs to monitor for R1 to encourage a calm atmosphere for him in this setting. The facility's final investigation report for R1 and R2's incident on 5/14/2025 said At this time, it appears that the contact between R1 and R2 was accidental and unintentional. R1 is best suited in a different setting. The facility's policy titled Behavior Management Policy and Procedure dated 12/18/2024 said Purpose- To ensure a safe, respectful, and therapeutic environment by providing consistent guidelines for identifying, preventing, and managing challenging or disruptive behaviors in residents while preserving their dignity and rights. The facility's policy titled Abuse Prevention Training Program undated said The objective of the Abuse Prevention Program is to comply with the seven-step approach to abuse and neglect detection and prevention .I. PREVENTION & SCREENING .II. IDENTIFICATION AND INTERNAL REPORTING .III. PROTECTION .IV. INVESTIGATION .V. REPORTNG & RESPONSE .Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is also the willful infliction of injury unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse .Willful, as used in this definition of abuse, means the individual must have acted deliberately .Physical Abuse includes hitting, slapping, pinching, kicking .Sexual Abuse is non-consensual sexual contact of any type with a resident Mental Abuse is also the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. This includes, but is not limited to, harassing a resident; mocking, insulting, or ridiculing; yelling or hovering over a resident, with the intent to intimate .Abuse is most likely to happen in situations that result in frustration, annoyance, and anger .To prevent these situations from turning into a possibly abusive situation, you must know the causes of why a resident gets agitated or aggressive .Some of those causes could be .Dementia .Sudden movements, startling noises .