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	10/23/2024

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. 37232 Based on observation, interview, and record review the facility failed to implement a fluid restriction for a resident with congestive heart failure (CHF) and failed to do daily weights for residents with CHF. This applies to 3 of 29 residents (R6, R13, and R82) reviewed for quality of care in the sample of 29. The findings include: 1. R6's Face Sheet printed on 10/22/24 showed R6 had a diagnosis of CHF. R6's Order Summary report showed an order for a fluid restriction of 2-2.5 liters per day. The order had a start date of 10/10/24. On 10/22/24 at 10:27 AM, V2 (Director of Nursing) said R6 was on a fluid restriction for CHF. On 10/22/24 at 11:15 AM, R6 said she was not aware if she was on a fluid restriction. On 10/21/24 at 12:18 PM, on R6's bedside table was a large disposable foam cup, two plastic cups, a dietary supplement drink (in its original container), and a container of milk. The large disposable foam cup appeared to be full. One plastic cup was half full. The other plastic cup was three quarters full. The dietary supplement drink appeared full. The container of milk was unopened. On 10/22/24 at 8:45 AM, behind the nurses station was a sign that indicated what residents were on a fluid restriction. The sign did not indicate R6 was on a fluid restriction. On 10/22/24 at 09:43 AM, V4 (Dietary Manager) said if a resident had an order for fluid restriction the nursing staff would notify dietary. The fluid restriction will be placed on the resident's meal ticket. V4 added the kitchen will not send any fluids for a resident on a fluid restriction. V4 said there are fluid stations on each hallway and the nursing staff will be responsible for providing the fluids. On 10/22/24 at 1:02 PM, R6's tray from the kitchen had a cup of juice and coffee on it. The meal ticket on the tray did not indicate R6 was on a fluid restriction. (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 10/22/24 at 10:01 AM, V9 (Certified Nursing Assistant - CNA) said she was taking care of R6. V9 said if a resident is on a fluid restriction the nurses will verbally let the CNAs know and it will be on the meal ticket. V9 said R6 was not on a fluid restriction. 2. R82's Face Sheet printed on 10/21/24 showed R82 was diagnosed with heart failure. R82's Order Summary Report printed on 10/21/24 showed an order for daily weights starting on 7/15/24. R82's Medication Administration Record (MAR) for October showed R82 was to be weighed daily. On the MAR there was a, X documented and no numerical number recorded for the weights. R82's Weights and Vitals Summary for 10/1/24 - 10/21/24 had no recorded dates for 10/1/24, 10/2/24, 10/3/24, 10/4/24, 10/7/24, 10/8/14, 10/11/24, 10/12/24, 10/13/24, 10/15/24, 10/17/24, 10/18/24, and 10/19/24 (missing weights for 13 out of 20 days). 3. R13's Face Sheet printed on 10/21/24 showed R13 was diagnosed with CHF. R13's Order Summary Report printed on 10/21/24 showed an order for daily weights starting on 6/3/24. R13's MAR for October and Weights and Vitals Summary for 10/1/24 - 10/21/24 showed missing weights on 10/3/24, 10/5/24, 10/11/24, 10/13/24, and 10/16/24 (missing weights for 5 out of 20 days). On 10/22/24 at 10:27 AM, V2 said for residents with CHF weights are done to monitor for fluid retention. V2 added that weights are recorded on the MAR and Weights and Vitals Summary.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35119 Based on observation, interview, and record review the facility failed to ensure a resident's arm was supported by a sling during a transfer and while up in the wheelchair for 1 of 6 residents (R105) reviewed for range of motion in the sample of 29. The findings include: On 10/21/24 at 10:30 AM , R105 was in bed. R105's left arm was resting on her stomach. R105 said she had a stroke and was unable to move her left arm or hand. There was a sign on the wall above R105's bed that read Must wear sling when being transported. At 10:32 AM, V15 (Certified Nursing Assistant) and V16 (Occupational Therapy) came into the room and provided incontinence care. V15 and V16 then rolled R105 from side to side to place a mechanical lift sling underneath her. R105 held her left wrist with her right hand while being rolled. V15 and V16 connected the mechanical lift sling the the lift machine and began raising R105 in the air. V16 told R105 to hold her arm. R105 was transferred via the mechanical lift to her wheelchair. R105 was then pushed down the hall to the nurses station. R105's left hand/arm rested in her lap in the wheelchair. R105 did not have a sling on her left arm. On 10/21/24 at 12:21 PM, R105 was sitting up in her wheelchair at the nurses station with her head lowered, sleeping. R105's left arm was resting in her lap with no sling in place. R105's Physician Orders for October 2024 shows R105 was admitted on [DATE] with diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. There is no order for a sling to R105's left arm. On 10/22/24 at 12:05 PM, V13 (Certified Nursing Assistant) said R105 transfers with a mechanical lift that requires a sling but she was not sure about any sling for her left arm or what the sign on the wall meant. On 10/22/24 at 12:08 PM, V14 (Registered Nurse/RN) said R105 must be wearing a mechanical lift sling to transfer, but was not sure about an arm sling and had never seen her wearing a sling on her arm since admission. On 10/22/24 at 12:08 PM, V7 (RN/Infection Preventionist) had never seen the sign above R105's bed and was not sure what it meant. V7 said she was not sure about a sling for R105's left arm and was going to call R105's daughter to see if she placed the sign and what it meant. On 10/22/24 at 2:29 PM, V16 (Occupational Therapy) said R105 should have sling on her left arm during transfer with the mechanical lift for support to prevent subluxation of her left shoulder. V16 said when R105 is out of bed and up in her chair, she should have a sling on her left arm. V16 said when R105 was admitted , the sling was the recommendation from R105's admission papers. V16 said nursing adds the admission orders and should have put the order in for the sling to her left arm when out of bed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R105's Occupation Therapy in R105's admission papers is dated 7/23/24 and shows left sling on when out of bed. R105's Physician Progress Note dated 7/31/2024 shows Today's visit (7/31): Patient seen completing therapy and later at bedside. She wears a sling to prevent shoulder subluxation. On exam: Left weakness worse in UE (upper extremity) than LE (lower extremity), UE flaccidity, Right UE and LE moving normally against gravity, shoulder subluxation present on LUE (left upper extremity). - continue orthosis for Left shoulder to reduce impact of flaccidity. The patient is at risk of increased subluxation. A sling is generally useful when the patient is sitting up. She may benefit from a tray or other support to maintain the arm in a position to eliminate gravity from providing traction to the Left shoulder, while allowing range of motion, as possible. While supine, the patient should have pillows, or bolsters, at the shoulder to minimize anterior / posterior traction. Patient was discussed with nursing and therapy.

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F 0689 Level of Harm - Minimal harm or potential for 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** 37232 Based on observation, interview, and record review the facility failed to ensure a resident with a diagnosis of dysphagia (difficulty swallowing) was cued/followed safe swallowing strategies, failed to transfer a resident in a safe manner, and failed to have a fall intervention in place for a resident at risk for falling. This applies to 3 of 29 residents (R3, R73, and R92) reviewed for safety in the sample of 29. The findings include: 1. R3's Face Sheet printed on 10/21/24 showed R3 was diagnosed with adult failure to thrive and dysphagia. On 10/21/24 at 1:10 PM, R3 was eating in her room with no staff present. R3 fed herself three consecutive spoonfuls of mechanical soft chicken. The spoonfuls appeared full with food falling off of the spoon as R3 moved the spoon towards her mouth. R3 did not alternate between food/solids and liquids. On 10/21/24 at 1:18 PM, R3 said she was done eating. Food was falling out of R3's mouth as she was talking. R3 had a cup of water and juice sitting on the meal tray. The cups appeared to be full when R3 said she was done eating. R3's care plan initiated on 9/20/24 showed R3 had cognitive impairments. The care plan initiated on 9/23/24 showed R3 had swallowing problems and pocketed food. Listed under interventions was to alternate between small bites and sips. The same care plan showed all staff were to be informed of R3's special dietary and safety needs. R3's Speech Therapy note dated 9/23/24 showed R3 needed cues to follow safe swallow strategies. The recommendations listed small/single bites and to alternate between food and liquids. The same note showed R3's cognition was severely impaired. On 10/22/24 at 10:06 AM, V10 (Speech Therapist) said R3 was at risk for aspirating and was confused. V10 said Speech recommended for R3 to alternate between small bits and liquids. V10 said alternating solids and liquids would help food go down. V10 added that R3 needed to be reminded to drink with meals. V10 said the recommendations by speech would help limit R3's aspiration risk. On 10/23/24 at 10:08 AM, V11 (Certified Nursing Assistant - CNA) said she was the CNA taking care of R3 and was familiar with R3. V11 said R3 eats on her own and did not need any cuing/reminding. 40798 2. On 10/21/24 at 9:51 AM, V18 (CNA) was seen leaving R73's room with the Full Lift mechanical (Hoyer) lift. V18 said she just used the mechanical lift to get R73 out of bed into his wheelchair by herself. R73 said sometimes two people get him out of bed, but today there was only one. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/24 at 10:30 AM, V2 (Director of Nursing), said two staff are required to transfer a patient with a Hoyer (mechanical lift) for safety reasons. R73's Admission Record dated 10/22/24 shows R73 is a [AGE] year old man and his diagnoses include, but are not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dysarthria following nontraumatic subarachnoid hemorrhage, gastrostomy status, and hypertension. R73's current care plan provided by the facility shows he requires a mechanical lift with two staff assistance for transfers. The facility's Resident Handling Limited Lift Policy (last reviewed 4/23/24) shows two caregivers are required for full lift/Hoyer transfers. 35119 3. On 10/21/24 at 9:31 AM, R92 was in bed with fall mats on either side of the bed. R92's call light was on the floor under the bed. On 10/22/24 at 9:22 AM, R92's call light was draped over the head of bed under the edge of the mattress, not within reach. On 10/22/24 at 10:44 AM, V7 (RN/Infection Preventionist) said R92 is able to use the call light when she needs help. On 10/22/24 at 10:45 AM, R92's call light remained draped over head of the bed still not in reach. R92's Fall assessment dated [DATE] shows R92 is at high risk for falls. R92's Care Plan dated 9/22/23 shows R92 has had an actual fall and is a high risk for falls due to poor safety awareness, cognitively impaired, poor communication, unable to preposition self, needing assistance from staff for activities of daily living and dependent with transfers with intervention: Be sure the resident's call light is within reach and encourage resident to use it for assistance as needed. The facility's Fall Prevention and Management Policy dated 4/8/24 shows Universal Fall Precautions/Facility Fall Protocol will be implemented to all residents admitted to the facility regardless of risk scores. High risk residents and patients for falls will receive individualized interventions as appropriate for risk factor.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 45540 Based on interview and record review, the facility failed to ensure PRN (as needed) anti-anxiety (psychotropic) medications had a duration/end date for 4 of 8 residents (R66, R40, R299, R106) reviewed for unnecessary medications in the sample of 29. 1. R66's Order Summary Report dated 10/22/24 shows an active order for Lorazepam (an anti-anxiety medication) 2mg (milligram)/mL (milliliter) give 0.5mL by mouth every 2 hours as needed for severe anxiety/nausea started on 5/31/24 with no duration listed. On 10/23/24 at 11:04 AM, V2 (Director of Nursing/DON) said PRN (as needed) antipsychotic and psychotropic medications should have a stop date or duration. 35119 2. R40's Physician Orders for October 2024 shows an order dated 9/19/24 for Lorazepam Oral Tablet 0.5mg tablet by mouth every 8 hours as needed for restlessness related to anxiety disorder. There is no stop date listed for this order. 37232 3. R299's Order Summary Report printed on 10/22/24 showed an order for Lorazepam (anti-anxiety psychotropic medication) to be given every 2 hours as needed starting on 10/20/24. There was no stop date/duration for the order. 4. R106's order summary report printed on 10/23/24 showed and order for Xanax (anti-anxiety psychotropic medication) to be given as needed twice a day starting on 5/23/24. There was no stop date/duration for the order. On 10/23/24 at 11:04 AM, V2 (Director of Nursing) said psychotropic medications ordered as needed should have a stop date/duration. The facility's Psychotropic Drug Use policy with a revised date of 1/31/24, showed if a resident had as needed psychotropic medication orders, it cannot exceed 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the as needed order to be extended beyond 14 days, documentation should be included in the patient's chart and indicate the duration of the order.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 35119 Based on observation, interview, and record review the facility failed to dispose of expired medications in the medication refrigerator for 2 of 29 residents (R120, R89) reviewed for medications in the sample of 29. The findings include: On 10/23/24 at 10:17 AM, V7 (Registered Nurse/Infection Preventionist) with this surveyor reviewed the medication room refrigerator. The refrigerator contained R120's used insulin pen with an opened date of 9/3/24 and an expiration date of 10/1/24 (22 days ago). The same refrigerator contained a bottle of liquid medicated mouthwash for R89 with an opened date of 7/12/24 written on the pharmacy sticker. The same pharmacy sticker shows discard after 14 days. V7 said those medications should have been thrown away since they are expired and she will dispose of them. The facility's Storage of Medications Policy dated 10/17/24 shows All expired medications will be removed from the active supply and destroyed in the facility,regardless of amount remaining.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40798 Based on observation, interview, and record review, the facility failed to ensure staff wore gowns when providing direct patient care to 1 of 29 residents (R73) on Enhanced Barrier Precautions (EBP) in the sample of 29 reviewed for infection control. The findings include: On 10/21/24 at 9:51 AM, V18, (Certified Nursing Assistant/CNA), changed R73's shirt and adjusted his neck pillow, wiped saliva from his mouth, and adjusted him in his wheelchair. V18 was not wearing a gown when providing R73's care. R73's room had PPE (personal protective equipment) in a container outside of his room and a sign on his door showing he is on EBP. On 10/22/24 at 1:40 PM, V7, (Registered Nurse/Infection Preventionist), said the staff is expected to wear a gown and gloves when providing high contact care (transferring, repositioning, toileting) a resident on EBP. R73's Admission Record dated 10/22/24 shows R73 is a [AGE] year-old man, and his diagnoses include, but are not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dysarthria following nontraumatic subarachnoid hemorrhage, gastrostomy status, and hypertension. The facility's Enhanced Barrier Precautions list dated 10/21/24 shows R73 is on EBP for a gastrostomy tube. The facility's Enhanced Barrier Precautions Policy (revised 3/28/24) shows EBP is an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of Multidrug Resistant Organisms (MDRO). EBP are applied when residents have an indwelling medical device such as a feeding tube. Examples of high contact resident care activities includes dressing and providing hygiene.