

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145803	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/04/2024
NAME OF PROVIDER OR SUPPLIER  Pearl of Evanston,the		STREET ADDRESS, CITY, STATE, ZIP CODE 820 Foster Street Evanston, IL 60201	

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41692</b></p> <p>Based on interviews and record reviews, the facility failed to investigate thoroughly and report an altercation of potential abuse. This applies to two residents: (R1 and R2) of six residents reviewed for potential abuse.</p> <p>Findings Include:</p> <p>R1 is a [AGE] year old male originally admitted on [DATE] with medical diagnosis that includes but not limited to: Parkinson's disease without dyskinesia, anxiety disorder, obsessive compulsive disorder and spinal stenosis. R1 is ambulatory and independent on all activities of daily living. Minimum Data Set (MDS) reads, BIMS (Brief Interview for Mental Status), dated: [DATE] score of 15/15 indicating intact cognition.</p> <p>R2 is a [AGE] year old male originally admitted on [DATE] with medical diagnosis that includes and but not limited to: epilepsy, Alzheimer's disease, and anxiety disorder R2 is wheelchair dependent and is a total care for all activities of daily living. Minimum data set- reads, BIMS (Brief Interview for Mental Status) score of 5/15 indicating a severe cognitive impairment.</p> <p>On 11-2-2024 at 11:10 am V9 (Housekeeping/ Maintenance Aide) said, On 10-10-2024 after dinner probably about 6:00 pm, I was cleaning the floor in the third-floor dining room. R1 was the only person in the dining room. He was sitting at a table by himself using a computer. R2 came into the dining room. R2 was propelling himself in a wheelchair using both hands. R2 approached R1's table. They (R1 and R2) became very loud, screaming at each other. I did not know what had happened. I became so nervous and scared that I ran out of the dining room. I left them alone. I went to look for any nursing staff to come and assist to de-escalate the situation. I know it was my fault for leaving them alone because they could have hurt each other. I do not know how long it took me to find a female nurse at the end of the hallway. I reported to the nurse that R1 and R3 were arguing, and I did not know what to do. V10 (Licensed Practical Nurse) and I went into the dining room, and we saw that a heavy dining room table was flipped over. R1 and R2 appeared to be ok. I do not know who turned over the table. It happened when I was looking for the nurse. V10 came into the room and separated the residents. R1 left the room very upset and said, I am calling the police. The police came at about 6:40 pm. No manager talked or asked me what had happened or requested for me to write any statement.</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11-2-2024 at 10:25 am V1 (Director of Nursing) said, I was told by V14 (Administrator) that R1 and R2 had a verbal altercation. I did not investigate. I did not interview anyone about it. I do not have any file with any reportable or internal investigation for that incident. V14 is the abuse coordinator and is responsible for investigating any alleged abuse incidents.</p> <p>On 11-2-2024 at 12:45 pm V14 (Administrator) said, on 10-10-2024 R1 had a verbal altercation with R2, with no physical contact. V16 (nurse supervisor) and V10 (nurse), reported that the police were here completing a police report. V14 said, I did not report the incident to IDPH, after an altercation and investigation needs to be done. I did not talk to V9 (housekeeper). I should had spoken and obtain an interview and investigate the incident thoroughly.</p> <p>V1 (Director of Nursing) presented police titled: Abuse Prevention Program, undated. Reads: Residents have the right to be free from abuse. The purpose of this policy and abuse prevention program is to describe the process for identification, assessment, and protection of residents from abuse. This will be accomplished by:</p> <ol style="list-style-type: none"> <li>1. Implementing a system to promptly and aggressively investigate all reports and allegations of abuse.</li> <li>2. Investigation, as soon as possible after the allegation of abuse, the administrator or designee will initiate an investigation into the allegation which may include:             <ol style="list-style-type: none"> <li>a. Interviewing all persons who may have knowledge of the alleged incident.</li> <li>b. Any staff having contact with the resident during the period of the alleged incident.</li> <li>c. Review all circumstances surrounding the incident.</li> </ol> </li> <li>3. Filing accurately and timely investigation reports.</li> </ol>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41692</p> <p>Based on interview and record review the facility failed to follow its abuse policy by not ensuring:</p> <ol style="list-style-type: none"> <li>All staff are trained and are knowledgeable on how to react to a resident-to-resident altercation.</li> <li>All staff upon hire will have the required abuse, neglect and exploitation training.</li> </ol> <p>These failures resulted in two residents R1 and R2 being left alone during an altercation.</p> <p><b>FINDINGS INCLUDE:</b></p> <p>R1 is a [AGE] year old male originally admitted on [DATE] with medical diagnosis that includes but not limited to: Parkinson's disease without dyskinesia, anxiety disorder, obsessive compulsive disorder and spinal stenosis. R1 is ambulatory and independent on all activities of daily living. Minimum Data Set (MDS) reads, BIMS (Brief Interview for Mental Status), dated: [DATE] score of 15/15 indicating intact cognition.</p> <p>R2 is a [AGE] year old male originally admitted on [DATE] with medical diagnosis that includes but not limited to: epilepsy, Alzheimer's disease, and anxiety disorder R2 is wheelchair dependent and is a total care for all activities of daily living. Minimum data set- reads, BIMS (Brief Interview for Mental Status) score of 5/15 indicating a severe cognitive impairment.</p> <p>On 11-2-2024 at 11:10 am V9 (Housekeeping/ Maintenance Aide) said, On 10-10-2024 after dinner probably about 6:00 pm, I was cleaning the floor in the third-floor dining room. R1 was the only person in the dining room. He was sitting at a table by himself using a computer. R2 came into the dining room. R2 was propelling himself in a wheelchair using both hands. R2 approached R1's table. They (R1 and R2) became very loud, screaming at each other. I did not know what had happened. I became so nervous and scared that I ran out of the dining room. I left them alone. I went to look for any nursing staff to come and assist to de-escalate the situation. I know it was my fault for leaving them alone because they could have hurt each other. I do not know how long it took me to find a female nurse at the end of the hallway. I reported to the nurse that R1 and R3 were arguing, and I did not know what to do. V10 (Licensed Practical Nurse) and I went into the dining room, and we saw that a heavy dining room table was flipped over. R1 and R2 appeared to be ok. I do not know who turned over the table. It happened when I was looking for the nurse. V10 came into the room and separated the residents. R1 left the room very upset and said, I am calling the police. The police came at about 6:40 pm. No manager talked or asked me what had happened or requested for me to write any statement. V9 said, I did not receive any abuse training. I do not know what to do when abuse is taking place or how to manage the situation. I started working here five months ago.</p> <p>On 11-3-2024 at 11:00 am V5 (licensed Practical Nurse) said, I have been working here for 3 months, and I do not remember having any abuse training.</p> <p>(continued on next page)</p>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11-3-2024 at 11:20 am V19 (Licensed Practical Nurse) said, I have been working here for 2 months. I know about abuse because when I went to Certified Nurse Assistant training in 2021, they explained to me. I have not received any abuse training since I have been working here.</p> <p>On 11-3-2024 at 2:00 pm V23 (Housekeeping Supervisor) said, I am responsible for training the new staff members that come into the department. I did not provide an abuse orientation to V9 because he works in the afternoon and my schedule is in the morning. I will make sure to train him now.</p> <p>On 11-2-2024 at 2:45 pm V1 (director of Nursing) said, All new staff members need to be trained on abuse, the kinds of abuse, what to do if an altercation takes place, not to leave the residents unattended, and who to report the abuse. The abuse coordinator is the administrator (V14). The last abuse review we had was on 10-1-2024 during our town meeting.</p> <p>V1 (Director of Nursing) presented police titled: Abuse Prevention Program, undated. Reads: Residents have the right to be free from abuse. The purpose of this policy and abuse prevention program is to describe the process for identification, assessment, and protection of residents from abuse. This will be accomplished by:</p> <ol style="list-style-type: none"> <li>1. Orientating and training employees on how to deal with stress and difficult situations</li> <li>2. Immediately protecting residents involved in identified reports of possible abuse.</li> <li>3. During orientation and annually thereafter, staff will receive education about resident abuse.</li> </ol>		