STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145821	A. Building B. Wing	08/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Elgin, The	2355 Royal Boulevard Elgin, IL 60123

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview and record review, the facility failed to inform a resident's Power of Attorney (POA) before facilitating the completion of guardianship paperwork by another family member.This applies to 1 of 6 residents (R1) reviewed for the right exercised by the representative.Findings include:On 08/28/2025, approximately at 11:45 AM, V10 (R1's POA) said the facility facilitated the completion of R1's guardianship for another family member without her knowledge or consent. The Power of Attorney for Healthcare Statutory Form dated 02/19/2025, signed by R1, listed V10 as his healthcare agent (Power of Attorney-POA). Under the facility contact information in R1's profile, V10 is entered as the POA, responsible party for Healthcare Care, Surrogate Decision Maker, and Emergency Contact # 1.The facility provided a completed and signed evaluation report form for R1's guardianship, dated 8/12/2025, that was requested by a non-POA family member without the consent of V10, and the report was given to the non-POA family member.R1's EMR (Electronic Medical Record) showed that R1 is an [AGE] year-old male who was admitted to the facility on [DATE] for therapies, medical oversight, and assistance with activities of daily living. The SLUMS (St. Louis University Mental Status Examination), a comprehensive cognitive assessment dated [DATE], showed that R1 was cognitively impaired. R1's care plan, dated 06/27/2025, showed that R1's judgment was impaired. On 08/28/2025 at 11:30 AM, V2 (Social Services Director) stated that R1's non-POA family member provided her with a legal letterhead guardianship form on 08/05/2025 for the physician to complete the health information portion. V2 said she thought the Attorney would have been dealing with it and did not realize she needed to go through V10's (POA) authorization. V2 said she had given the form to V1(Administrator) to facilitate further. V2 said R1 never expressed to her about a change of guardianship, and she should have honored the wishes of R1 and notified V10 for the consent.On 08/28/2025 at 3:00 PM, V1 (Administrator) stated that V2 provided the form to him, and he facilitated its completion by V3 (R1's Physician). V1 stated the completed form was provided to the non-POA family member on 08/13/2025. V1 also said R1 did not express any desire to him for a change of guardianship, and he should have honored the wishes of V10 (POA), R1's previously designated POA.The facility's policy, titled Notification of Change of Condition, Discharge, and Transfer, dated 06/06/2025, states in part that The resident representative shall be notified of a change in resident rights under federal or state law or regulations .

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