

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145821	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/22/2024
NAME OF PROVIDER OR SUPPLIER  Pearl of Elgin, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43389</p> <p>Based on interview and record review, the facility failed to ensure that residents were able to exercise their right to make a complaint without interference. The facility also failed to document resident's concerns and follow their grievance policy. This applies to 3 of 3 residents (R13, R26, and R76) reviewed for grievances in the sample of 24.</p> <p>The findings include:</p> <p>1. R76 is a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that include Pulmonary Embolism, Chest Pain, and Sleep Apnea.</p> <p>R13 is a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that include Asthma, Diabetes insipidus, and Major Depressive Disorder.</p> <p>R26 is [AGE] year-old female admitted to the facility on [DATE], with diagnoses that include Osteoarthritis of knee, Type 2 Diabetes Mellitus, Major depressive disorder, and Dementia.</p> <p>All three women are cognitively intact as evidenced by their most recent Brief Interview for Mental Status (BIMS) score of 15/15.</p> <p>During the resident council meeting on August 20, 2024, at 1:32 PM, R76 stated she was afraid of retaliation by the staff for voicing complaints because a female staff member asked her not to complain to the surveyor the day before so the facility can pass the survey. R13 and R26 also confirmed that a female staff member also told them the same.</p> <p>On August 21, 2024 at 10:01 AM, R76 stated she was conflicted and concerned about retaliation when V2 (Director of Nursing) approached her and R24 and asked them not to complain about the facility to the state surveyor. R76 stated I felt intimidated. I thought that by me complaining and them not passing, whatever passing meant, then there would be changes and I would be out of a place to live.</p> <p>On August 21, 2024, at 10:18 AM, R26 stated that when she was told not to complain about the bad stuff at the facility by V2, she felt like they were watching her more closely and it made her feel uncomfortable.</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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On August 21, 2024, at 11:22 AM, R13 stated when V2 told her not to complain to the state surveyors, it felt [NAME] like they wanted her to lie to make them look good. R13 stated she fears retaliation and she doesn't want any trouble.</p> <p>On August 21, 2024, at 2:37 PM, V25 (Social Service Director/Grievance Coordinator) stated that residents have a right to make a grievance, and they should be able to make a grievance without fear of retaliation. V25 stated residents should be able to voice concerns and grievances. This is their home. V25 stated staff should not ask residents not to complain.</p> <p>The facility's Resident Rights policy dated January 17, 2024 showed the following:</p> <p>7. The facility will ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>48308</p> <p>2. August 21, 2024, at 9:50 AM, R26 stated she would like resolution to her concern of having missing dentures. R26 stated she had dentures when she was admitted and around the beginning of the year, 2024, R26 stated the dentures were missing. R26 stated one morning she left her dentures cleaning in a cup on the sink in her bathroom and went to eat breakfast. R26 stated when she returned to her room after breakfast, her denture cup was gone, and she was unable to find her denture cup, but her room had been cleaned. R26 stated she reported the missing dentures to nursing staff but is unable to remember the names of the staff she told.</p> <p>R26's MDS dated [DATE] showed R26 was cognitively intact.</p> <p>R26's progress note dated April 27, 2024, showed V30 (Registered Nurse) documented R26's upper denture was missing.</p> <p>Review of the facility's grievance log from April 2024 through August 19, 2024, showed there was no grievance form on R26's behalf for missing dentures.</p> <p>On August 21, 2024, at 1:30 PM, V1 (Administrator) stated the Grievances are handled through social services first and the Social Services Director is the grievance coordinator. V1 stated grievance forms are completed for lost items if it can't be addressed immediately, staff will document on the grievance form. V1 stated when R26 raised the concern of the missing denture, staff working with R26 should have known to complete a grievance form as the staff on that unit are staff that have worked in the facility for a long time.</p> <p>On August 21, 2024, at 1:55 PM, V25 (Social Services Director/Grievance Coordinator) stated she is the Grievance Coordinator and if any staff become aware of a resident's missing item, the staff should complete a grievance form. V25 stated she was unaware of R26's missing dentures until the surveyor brought the concern to V1 (Administrators) attention on August 20, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Facility's grievance policy titled Grievance Program dated May 15, 2024, showed Policy .2. Process: a. grievances are formal written or verbal complaints made to the facility when prompt or bedside resolution to the satisfaction of the person making the objection was not possible. Grievances can also be made anonymously. When there is a grievance, it will be: .i. Documented on the facility Grievance Report. ii. Routed to the Grievance Officer. iii. Listed on the facility Grievance Log .v. Investigated accordingly .viii. Discussed through meetings which may be in person and/or telephone conferences .5. When a grievance is received by a staff member, they will notify their supervisor and forward the completed report to the Grievance Official.6. When a grievance is received orally, and the resident does not choose to complete a written report; then the staff member receiving the grievance will complete the report and forward it to the Grievance Official.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>36567</p> <p>Based on interview and record review, the facility failed to conduct a screening for Preadmission Screening and Resident Review (PASRR) on admission to facility for a resident with mental disorder. This applies to 1 of 4 residents (R21) reviewed for PASRR in the sample of 24.</p> <p>The findings include:</p> <p>R21's face sheet included diagnoses of schizophrenia, unspecified, anxiety disorder, unspecified major depressive disorder, recurrent, moderate Parkinson's disease without dyskinesia, without mention of fluctuations.</p> <p>R21's quarterly MDS (Minimum Data Set) dated July 5, 2024 showed that R21 is moderately impaired in cognition.</p> <p>Notice of PASRR Level I Screen Outcome dated July 25, 2022 included as follows: You are receiving this notification because you received a Preadmission Screening and Resident Review (PASRR) screening. To learn more, read the additional PASRR information that came with this letter.</p> <p>PASRR OUTCOME Explanation: PASRR request has been canceled. On behalf of the (state agency and state agency's contracted provider) has reviewed the Preadmission Screening and Resident Review (PASRR) Level 1 screen that was completed for you by your health care professional. You received this screen because you are seeking to enter or continue to stay in a nursing facility that receives Medicaid funding. PASRR Level I screen are required by Federal law, 42 U.S.C &amp; 1396r(e)(7).</p> <p>Your Level I screen has been canceled by (state agency's contracted provider) . The screen was canceled because your health care professional did not complete either the Level 1 screening form and/or submit requested documentation within the required timeframe. If you want to go to a nursing facility, the nursing facility must submit a completed Level I screening to (state agency's contracted provider).</p> <p>On August 20, 2024 at 9:10 AM, V3 (Admissions Director) stated that R21 has been at the facility since 2021. V3 stated that on admission, all residents get a screening for PASRR and DON (Determination of need) and 90% of the time it is done at the hospital. V3 stated that the facility does check to ensure that everyone has been screened for PASRR, but she does not know the frequency of when it is done. V3 stated that she reached out to (state agency's contracted provider) on August 19, 2024 when PASRR level I for R21 was requested for during survey and they stated that a screening for the same have to be requested for again.</p> <p>Facility Policy titled Admission Criteria (dated November 18, 2021) included as follows:</p> <p>Policy Statement: Our facility admits only residents whose medical and nursing care can be met.</p> <p>Procedure: 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per Medicaid Preadmission Screening and Resident Review (PASARR) process.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD.</p> <p>b. If the level I screen indicates that the individual may meet the criteria for a MD, ID or RD, he or she is referred to the state PASARR representative for Level II (evaluation and determination) screening process.</p> <p>1) The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID or RD.</p> <p>2) The social worker is responsible for making referrals to the appropriate state-designated authority.</p>		

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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.  **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43389  Based on observation, interview, and record review, the facility failed to ensure that a resident's gauze central line dressing was changed every 48 hours for prevention of infection. This applies to 1 of 1 resident (R113) reviewed for intravenous therapy in the sample of 24.  The findings include:  R113 is a [AGE] year-old male admitted to the facility on [DATE], with diagnoses that include local infection of the skin and subcutaneous tissue, Sepsis, and Peritoneal Abscess.  R113 had an order dated August 1, 2024, to change transparent dressing using central line kit every week. Apply (brand name specialty dressing) on site, secure with (brand name stabilization device), and change cap.  On August 19, 2024, at 10:52 AM, R113's right arm central line dressing was dated August 11, 2024, in red marker. The dressing was dirty and covered with a dirty sleeve. There is a piece of gauze about two inches squared around the insertion site of the central line. On top of the gauze was a transparent semipermeable membrane. R113 stated his central line dressing had not been changed recently.  On August 19, 2024, at 1:28 PM, R113 stated that the nurse just changed his central line dressing. R113 central line dressing is now dated August 19, 2024 and gauze is mostly covering the insertion site with a transparent semipermeable dressing over it.  On August 21, 2024, at 1:52 PM, V2 (Director of Nursing) stated their practice is to use the central line kit to change central line dressing and they place the gauze that comes in the kit underneath the transparent dressing. V2 stated that there is no (brand name specialty dressing) in the kit. V2 stated their practice is to change the central line dressing every seven days and as needed. V2 stated they change the dressing to prevent infection. V2 stated she was not aware of the facility's policy to change dressing every 48 hours when gauze is used underneath a transparent membrane.  R113's electronic medication administration record document central line dressing was not being changed every 48 hours.  The facility's PICC line or Midline Catheter Dressing Change procedure policy shows the following: Procedure: 14. Note: When a transparent semipermeable membrane is applied over gauze, it is considered a gauze dressing in accordance with the intravenous Nursing Society Standards and must be changed every 48 hours.		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>48308</p> <p>Based on observation, interview, and record review the facility failed to store insulin and house stock medication in accordance with their policy. This applies to 1 of 24 residents (R10) reviewed for medication storage in a sample of 24.</p> <p>The findings include:</p> <p>On August 20, 2024, at 10:05 AM, the XXX Hall East medication cart was reviewed with V31 (LPN/Licensed Practical Nurse). R10's Basaglar insulin pen was unopened, stored in the drawer of the medication cart and the sticker on the package showed refrigerate until opened. The pharmacy filled date on the label was August 10, 2024. V31 stated that the insulin pen should be in the refrigerator because it was not opened.</p> <p>R10's physician order summary showed R10 had an active order for Basaglar insulin 60 units at bedtime daily.</p> <p>On August 20, 2024, at 10:30 AM, the East Medication Storage room was checked with V30 (Nurse Supervisor). In the cabinet where the house stock medications are stored, there were zinc sulfate capsules 220 mg, with expiration date of October 2023, and 3 bottles of multivitamins, 100 tablets each with an expiration date of July 2024. There was no other stock of zinc sulfate capsules or multi vitamin tablets in the medication cabinet.</p> <p>The facility policy titled Storage of Medications dated, September of 2018, showed II. Temperature .4. Medications requiring refrigeration are kept in a refrigerator at temperature between 36F (Fahrenheit) and 46F and III. Expiration Dating .8. All expired medications will be removed from the active supply and destroyed in accordance with facility policy, regardless of amount remaining.</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48308</b></p> <p>Based on observation, interview, and record review the facility failed to have the required policy regarding missing or lost dentures and financial responsibility, in accordance with 483.55(b)(4) and failed to assist a resident in need of dentures, to obtain them. This applies to 1 of 1 resident (R26) reviewed for dental services in the sample of 24.</p> <p>The Findings include:</p> <p>R26's EMR (Electronic Medical Record) showed R26 was admitted to the facility on [DATE], with multiple diagnoses including, Diabetes type 2, bilateral primary osteoarthritis of both knees, unspecified protein-calorie malnutrition, chronic obstructive pulmonary disease, and chronic diastolic congestive heart failure. R26's payor status showed Medicaid pending.</p> <p>R26's MDS (Minimum Data Set) dated July 27, 2024, showed R26 to be cognitively intact, and required staff assistance with ADLs (Activities of Daily Living) including Supervision or touching assistance with eating, oral hygiene and upper body dressing, partial/moderate assistance with bed mobility and toilet transfer, and substantial assistance with lower body dressing and sit to stand, and dependent on staff with toilet hygiene, bathing and putting on footwear.</p> <p>R26's care plan initiated on August 8, 2024, showed personal hygiene/oral care the resident is able to cleanse her dentures with set up assistance from staff. R26's profile picture showed she had teeth.</p> <p>On August 19, 2024, at 2:02 PM, R26 was sitting in her room in her wheelchair, she had one bottom tooth in her mouth, when asked if she received dental services, R26 responded she had been missing her dentures since the beginning of 2024. R26 stated she doesn't remember the exact date, but she remembered leaving her dentures in the soaking solution in a cup on the bathroom sink and when she returned after eating breakfast, the cup and the dentures were missing. R26 stated since breakfast food is usually soft, she didn't need the dentures in to eat breakfast and her room had been cleaned while she was at breakfast but could no longer find her denture cup in her room and thought the cup was knocked off the sink and into the garbage during room cleaning. R26 stated she told her assigned nursing staff at the time but does not remember which staff she told and stated she had been to the dentist twice since that time but has no idea where the replacement dentures are now.</p> <p>A review of the facility's grievance/concern forms from April 2024 through August 19, 2024, showed there was no grievance made on behalf of R26 concern regarding missing dentures.</p> <p>R26's progress note dated April 27, 2024; quarterly review written by V30 (Registered Nurse) showed R26's dentures were missing.</p> <p>R26's dental visit notes dated April 30, 2024, showed the treatment plan to be upper denture/lower peep denture.</p> <p>R26's dental visit notes dated June 8, 2024, showed the treatment plan to be upper denture, extract root tip #29, lower peep hole denture, will check coverage. No symptomatic teeth.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On August 21, 2024, at 2:11 PM, V24 (Customer service for the dental office) stated when looking through R26's notes found that in response to R26's dental visit on April 30, 2024, the office sent an email to the facility's business office manager on May 1, 2024. V24 stated the email showed that the dental office described the costs for replacing R26's dentures as being \$300 each for the upper and lower denture or a total cost of \$600. V24 stated R26's notes showed there was no response from the facility to the May 1, 2024, email. V24 stated the notes showed the next contact from the facility regarding R26 was on August 20, 2024, requesting information regarding R26's denture replacement status. V24 stated since the financial arrangement for the cost of R26's dentures had not been completed, R26's denture replacements had not been started by the dental office.</p> <p>On August 21, 2024, at 1:30 PM, V1 (Administrator) stated when R26 raised the concern of the missing denture, staff working with R26 should have known to complete a grievance form as the staff on that unit are staff that have worked in the facility for a long time. V1 also stated that the dental visits are arranged by V25 (Social Services Director).</p> <p>On August 21, 2024, at 1:55 PM, V25 stated she does arrange for dental appointments and receives the dental visit notes from the dental office. V25 stated when she receives the dental visit notes she forwards the email to the health information staff who uploads the visit notes into the EMR of each resident. V25 was asked who in the facility reads and follows through with the treatment plans identified on the dental visit notes and V25 stated maybe nursing staff, if a preparation for a tooth extraction was ordered, but otherwise was unsure who read the notes and who arranged for follow up.</p> <p>The facility did not provide a policy regarding lost/missing dentures and determining financial responsibility for replacement.</p> <p>The facility policy titled Dental Services dated June 3, 2024, showed 2 c. Will promptly, at least within 3 days, refer residents with lost or damaged dentures for dental services .3. The facility will assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plans.</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>36567</p> <p>Based on observation, interview and record review, the facility failed to serve mechanically ground coleslaw and pureed consistency pork riblet and bun to residents on diet order consistencies for the same. This applies to 11 of 11 residents (R5, R8, R12, R34, R41, R46, R62, R65,R71, R168, R270) reviewed for dining in the sample of 24.</p> <p>The findings include:</p> <p>1. On August 19, 2024 at 12:11 PM, during tray line service, the pureed barbeque pork riblet was noted to be grainy with black substance in it. The pureed bread appeared granular. When taste tested , the pureed meat had hard pieces that were unable to be swallowed without being chewed. The black substance appeared to be burnt pieces from the pork riblet, as some of the riblets served for the regular consistency diet looked well done with charred ends. V17 (Food Service Manager) was notified that these items were not safe to serve. V19 (Cook) acknowledged that the black substances were from the charred pork riblets.</p> <p>Facility diet order sheet printed August 19, 2024 showed that R5, R46, R71, R168 and R270 were on Pureed diets.</p> <p>2. On August 19, 2024 at 01:17 PM, during meal rounds, R12 was fed by V21 (Certified Nursing Assistant) in her room. R12's head of the bed was elevated between 45-75-degree angle. R12 received mechanical soft riblet on bun, French fries and a side of coleslaw which was shredded into varying lengths. R12's meal ticket showed ground creamy coleslaw. V21 was feeding R12 the ground riblet and the bun that was cut up into pieces and shredded coleslaw that were mixed together on the plate. R12 noted to start coughing profusely and V21 was prompted to call the nurse on duty. V20 (Licensed Practical Nurse) came to the room and R12 continued to cough and stated that she needs to go to the hospital. On prompting again, V20 and V21 raised the head of bed to 90-degree angle. State Personnel stepped out of the room and returned to find R12 not coughing anymore. V20 stated that R12 coughed out a piece of food which looked like the coleslaw. When asked, R12 stated that most of her teeth are missing.</p> <p>Other residents observed for dining that showed mechanical soft diets on tray cards and who received the shredded coleslaw were R8, R34, R41, R62 and R65. R8 was noted not to touch her coleslaw and stated, It's hard to chew and I am afraid of choking if I eat it. V17 and V19 verified that the coleslaw was shredded and not ground.</p> <p>Facility diet order sheet printed August 19, 2024 showed that R8, R12, R34, R41, R62 and R65 were on mechanical soft diets.</p> <p>On August 20, 2024 at 11:40 AM, V18 (Regional Director of Operations, Dietary) stated that the consistency for pureed foods should be like mashed potato. V18 stated that the facility should follow the spreadsheets and/or recipe for mechanical soft coleslaw.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Facility Recipe for 'Creamy Coleslaw' included as follows: Shred or chop cabbage and measure and add coleslaw dressing appropriate for number of servings. For all textures modifications follow sheet for substitute.</p> <p>Facility Menu extension for August 19, 2024 showed that mechanical soft diet to receive ground creamy coleslaw.</p> <p>Facility undated policy titled Characteristics and Procedures for Consistency Modified Foods included as follows:</p> <p>Policy: Mechanical Soft, Dysphagia and Puree Diets will be prepared to the food characteristics listed below:</p> <p>Puree #440: Properly prepared pureed food has the following characteristics:</p> <ol style="list-style-type: none"> <li>1. It is smooth without lumps, skin pieces, etc.</li> <li>2. It holds its shape on a plate.</li> <li>3. It is soft (pudding like consistency)</li> <li>5. It does not need to be chewed.</li> </ol> <p>Ground: Mechanical Soft #435 (May also be called Soft, Bite Size). Properly prepared foods for residents requiring mechanical soft consistency have the following characteristics: 3. chewing is required before swallowing 4. Bite sized pieces no larger than 1/2 inch.</p> <p>Procedure: 2. Process in food processor until even course ground texture is achieved.</p>

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NAME OF PROVIDER OR SUPPLIER  Pearl of Elgin, The		STREET ADDRESS, CITY, STATE, ZIP CODE  2355 Royal Boulevard Elgin, IL 60123	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41855</b></p> <p>Based on observation, interview, and record review, the facility failed to follow their policy for hand hygiene during provisions of care with R59. The facility also failed to follow their water management plan for Legionella. This has the potential to affect all 121 residents residing in the facility.</p> <p>The findings include:</p> <p>1. R59's EMR (Electronic Medical Record) showed R59 was admitted to the facility on [DATE], with diagnoses that included wedge compression fracture of thoracic vertebra (T7-T8), wedge compression of first lumbar vertebrae, dementia, and cerebrovascular disease.</p> <p>R59's MDS (Minimum Data Set) dated July 8, 2024, showed R59 had cognitive impairment and was dependent on staff for toileting hygiene.</p> <p>R59's care plan showed R59 had an indwelling urinary catheter for urinary retention and catheter care was to be provided during routine perineal care.</p> <p>On August 21, 2024, at 1:13 PM, V15 and V14 (Certified Nursing Assistants) used hand sanitizer, put on gown and gloves to entered R59's room. V16 explained to R59 what they were there to do. V15 went into the bathroom and grabbed an empty container used to empty R59's urinary drainage bag. V15 emptied the drainage bag and then with the same gloves started providing care to R59. V15 used a packet of disposable wipes. V15 wiped the right groin with a wipe from front to back, she disposed of that wipe and used a new wipe to clean the left groin from front to back and threw that wipe away. V15 used a new wipe and cleaned down the outer labia from front to back and a small amount bowel movement was noted on the wipe. V15 did not spread the labia and clean in between the area. R59's indwelling catheter tubing was secured to the leg and V15 wiped down the top part of the tubing that was visible and did not clean the tubing from insertion site moving down the tubing towards her knee cleaning all sides of the tube. While wearing the same gloves, V15 with the help of V14, turned R59 onto her right side facing away from V15 so she could clean the resident's backside. Once on her right side, it was noted that R59 had a small amount of stool in her incontinence brief. V15 used a new wipe and cleaned her buttock several times (with a new wipe each time) from front to back. Once R59 was clean, V15, still wearing the same gloves grabbed the protective ointment they were using on her skin and applied it to R59's buttocks. V14 had laid a new incontinence on the bed behind R59 and used the same gloves to position the incontinence brief under R59 so she could be turned onto her left side. V14 stopped V15 and told her You need to change your gloves. V15 removed her gloves and without using hand sanitizer or soap and water put on a new pair of gloves. R59's incontinence brief was secured, she was repositioned and covered back up.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility provided their policy titled Hand Hygiene, with a revision date of June 3, 2024. The policy showed: Procedure: 1. Soap and water is required for hand hygiene when a. hands are visible soiled c. after potential exposure to body fluid h. after handling soiled or used linen, dressings, bedpans, catheters, and urinals. 2. Alcohol-based hand rub may be used for all other hand hygiene opportunities b. prior to performing a procedure such as blood glucose monitoring, invasive procedures or catheter care, c. when moving from a contaminated body site to a clean body site such as when changing a brief or wound dressing.</p> <p>On August 21, 2024, at 1:35 PM, V22 (Infection Preventionist Nurse) said that R59 was admitted to the facility with an indwelling urinary catheter in place. V22 said catheter care is to be done every shift. The staff need to gather their supplies and explain to resident what they will be doing. V22 said if the resident has had a bowel movement, the bowel movement should be cleaned up before doing the catheter care. After the bowel movement has been cleaned up, the staff need to remove gloves, perform hand hygiene, and put on new gloves. Staff then need to clean from the outer area moving inward and from front to back. In a female resident, the labia need to be spread and cleaned from front to back making sure to clean the tubing at the site of insertion moving away from resident and cleaning all sides of the tubing. V22 said anytime you touch something dirty when providing incontinence care, you need to remove gloves, do hand hygiene, and put on new gloves before touching anything clean. After cleaning up bowel movement, and before grabbing a container of ointment to be used on the bottom, dirty or used gloves need to be removed, hand hygiene done, and new gloves put on. This is to prevent cross contamination.</p> <p>45303</p> <p>2. The facility's Long-Term Care Facility Application for Medicare and Medicaid dated August 19, 2024, at 11:00 AM, showed the facility's census was 121 residents.</p> <p>On August 21, 2024, at 12:53 PM, V23 (Maintenance Director) said for the water management plan, he does not keep logs of the temperature gauge check of the Hot Water Tank, mixing valve, or kitchen/laundry water temperatures. V23 continued to say he does not check the facility's water for chlorine levels.</p> <p>The facility does not have documentation to show the temperate gauges are checked daily or the facility's water is tested for chlorine levels.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On August 20, 2024, V1 (Administrator) provided the facility's Water Management Plan dated February 21, 2024. The Plan continued to show the facility's Hazard Analysis of the facility's Cold-Water Distribution was Risk Basis: Medium Risk: Based on the potential variable chlorine present in the cold-water supply, the potential for microbiological growth in conjunction with the potential for water to be aerosolized present a medium risk at this processing step. In addition, distribution piping materials vary based on the various building ages and construction practices. Controls: 1. Systematic water flushing to move disinfectant through the piping system. 2. Emergency disinfection when indicated by added secondary disinfection to the cold-water system. 3. Temporary utilization of Point of Use Filters when indicated. 4. Identify, remove and/or mitigate potential dead-legs and/or cross connections that may exist within the distribution system. 5. Identify, remove and/or mitigate aerators/faucet flow restrictors that may exist within the distribution system. The Plan continued to show the Cold-Water Distribution's Critical Control Limit was Potable Water Oxidant: 'Free' Chlorine 0.2 to 4.0 ppm (Parts per Million); monitoring: Free Residual Oxidant Check (Chlorine; Frequency: weekly; Limit Deviation Corrective Action: Vacant resident care areas or any other area/room with plumbing fixtures are to be manually flushed for two minutes every day. The Plan continued to show the facility's Hazard Analysis of the facility's Hot Water Distribution was High Risk: The hot water system is extensive and complex. In addition, may tenants mange individual hot water heaters. There is a potential for 15-to-20-degree Fahrenheit temperature drops after the hot water supply leaved the Hot Water Heaters which can bring the water into prime temperature ranges for microbiological growth (105 degrees to 112 degrees Fahrenheit). Along with these favorable temperatures for microbiological growth, there is potential for free chlorine residuals to dissipate and leave the hot water system with low level of control. The factors for growth in conjunction with the potential for water to be aerosolized presents a high risk at this processing step. There is also potential for scalding should the Water Temperature not drop to 122 degrees Fahrenheit. In addition, distribution piping materials vary based on the various building ages and construction practices. Controls: 1. Temporary utilization of Point of Use filters when indicated. 2. Increase recirculation rate of hot water loops. 3. Identify, remove and/or mitigate potential dead-legs and/or cross connections that may exist within the distribution system. 4. Identify, remove and/or mitigate aerators/faucet flow restrictors that may exist within the distribution system. The Plan continued to show the Hot Water Distribution's Critical Control Limit was Potable Water Oxidant: 'Free' Chlorine 0.2 to 4.0 ppm (Parts per Million); monitoring: Free Residual Oxidant Check (Chlorine; Frequency: weekly; Limit Deviation Corrective Action: Vacant resident care areas or any other area/room with plumbing fixtures are to be manually flushed for two minutes every day.</p> <p>On August 21, 2024, at 2:33 PM, V1 (Administrator) said the facility has an updated water management plan. V1 continued to say the updated water management plan does not require chlorine testing. V1 said without chlorine testing, the facility does not know if the control limit of potable water oxidant chlorine in being met. V1 said in the new water management plan, the only monitoring for the Cold-Water Distribution and Hot Water Distribution is a yearly testing for Legionella in the facility's water. V1 continued to say there is no monitoring to mitigate the growth of Legionella in the Cold-Water Distribution or the Hot Water Distribution. V1 said the facility should have logs of daily temperature gauge checks. V1 said V23 checks the temperature gauges and V23 works Monday through Friday, so V1 is unsure who checks the temperature gauges on the weekends.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility's policy titled Policy: Legionella Water Management Plan dated May 15, 2024, showed, Policy Statement: Our facility is committed to the prevention, detection and control of water-borne contaminants including Legionella. Procedure: 1. As part of the infection prevention and control program, our facility has a water management team . 3. The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. 4. The water management program used by our facility is based on the Centers for Disease Control and Prevention and ASHRAE (American Society of Heating, Refrigerating and Air-Conditioning Engineers) recommendations for developing a Legionella water management program. 5. The water management program includes the following elements: a. An interdisciplinary water management team; b. A detailed description and diagram of the water system in the facility, including the following: 1) Receiving; 2) Cold water distribution; 3) Heating; 4) Hot water distribution; and 5) waste. c. The identification of areas in the areas in the water system that could encourage the growth and spread of Legionella or other water borne bacteria, including: 1) Storage tanks; 2) Water heaters; 3) Filters; 4) Aerators; 5) Showerheads and hoses; 6) Misters, atomizers, air washers and humidifiers; 7) Hot tubs; 8) Fountains; and 9) Medical devices such as CPAP (Continuous Positive Airway Pressure) machines, hydrotherapy equipment; etc. d. The identification of situations that can lead to Legionella growth, such as: 1) Construction; 2) Water Main breaks; 3) Changes in municipal water quality; 4) The presence of biofilm, scale or sediment; 5) Water temperature fluctuations; 6) Water pressure changes; 7) Water stagnation and; 8) inadequate disinfection. e. Specific measures used to control the introduction and/or spread of legionella (e.g., temperature, disinfectants); f. The control limits or parameters that are acceptable and that are monitored; g. A diagram of where control measures are applied; h. A system to monitor control limits and the effectiveness of control measures; i. A plan for when control limits are not met and/or control measures are not effective; and j. documentation of program .</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45303</b></p> <p>Based on interview and record review, the facility failed to follow their policy to offer pneumococcal vaccines in accordance with CDC (Centers for Disease Control and Prevention) guidelines. This applies to 5 of 5 residents (R1, R15, R21, R63, and R69) reviewed for immunizations in the sample of 24.</p> <p>The findings include:</p> <p>1. R1's EMR (Electronic Medical Record) showed R1 was a [AGE] year-old resident admitted to the facility on [DATE]. The EMR continued to show multiple interventions including congestive heart failure, respiratory disorders, asthma, pulmonary hypertension, and hypertension.</p> <p>R1's Immunization Report dated August 21, 2024, at 2:36 PM, showed R1 received the PPSV23 (23-valent pneumococcal polysaccharide vaccine) on July 13, 2022.</p> <p>The facility does not have documentation to show R1 was offered another pneumococcal vaccine.</p> <p>2. R15's EMR showed R15 was an [AGE] year-old resident admitted to the facility on [DATE]. The EMR continued to show R15 had multiple diagnoses including chronic kidney disease, acquired absence of kidney, hypertension, and hyperlipidemia.</p> <p>R15's Immunization Report dated August 21, 2024, at 2:34 PM, showed R15 received the PPSV23 on September 23, 2022.</p> <p>The facility does not have documentation to show R15 was offered another pneumococcal vaccine.</p> <p>3. R21's EMR showed R21 was an [AGE] year-old resident admitted to the facility on [DATE]. The EMR continued to show R22 had multiple diagnoses including Parkinson's disease, chronic kidney disease, hypertension, heart failure, and atrial fibrillation.</p> <p>R21's Immunization Report dated August 21, 2024, at 2:31 PM, showed R21 received the PPSV23 on July 13, 2022.</p> <p>The facility does not have documentation to show R21 was offered another pneumococcal vaccine.</p> <p>4. R63's EMR showed R63 was a [AGE] year-old resident admitted to the facility on [DATE]. The EMR continued to show R63 had multiple diagnoses including diastolic heart failure, atrial fibrillation, Parkinson's disease, and hypertension.</p> <p>R63's Immunization Report dated August 21, 2024, at 12:57 PM showed R63 had not received a pneumococcal vaccine. The report continued to show R63 required a pneumococcal vaccine.</p> <p>R63's Consent/Education Pneumonia assessment dated [DATE], at 2:40 PM, showed R63 consented to receive the pneumococcal vaccine.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility does not have documentation to show R63 received a pneumococcal vaccine.</p> <p>On August 21, 2024, at 2:04 PM V22 said R63's EMR did not show any other consents for pneumococcal vaccine.</p> <p>5. R69's EMR showed R69 was an [AGE] year-old resident admitted to the facility on [DATE]. The EMR continued to show R69 had multiple diagnoses including type 2 diabetes mellitus, chronic kidney disease, hyperlipidemia, and hypertension.</p> <p>R69's Immunization Report dated August 21, 2024, at 2:33 PM, showed R69 received the PPSV23 on July 13, 2022.</p> <p>The facility does not have documentation to show R69 was offered another pneumococcal vaccine.</p> <p>On August 21, 2024, at 2:04 PM, V22 (Infection Preventionist Nurse) said the facility follows the CDC's Pneumococcal Vaccine Timing for Adults. V22 continued to say R1, R15, R21, and R69 should have been offered another pneumococcal vaccine one year after the PPSV23, but none of them were offered another vaccine.</p> <p>On August 21, 2024, at 2:59 PM, V2 (Director of Nursing) said the facility follows CDC guidelines for pneumococcal vaccine timing. V2 continued to say R1, R15, R21, and R69 should have been offered another pneumococcal vaccine one year after receiving the PPSV23.</p> <p>The CDC's Pneumococcal Vaccine Timing for Adults showed adults [AGE] years and older with a prior vaccination of PPSV23 only should receive PCV20 (20-valent pneumococcal conjugate vaccine) or PCV15 (15-valent pneumococcal conjugate vaccine) after one year.</p> <p>The facility's policy titled Policy: Infection Control- Influenza and Pneumococcal Immunizations for Residents dated June 3, 2024, showed, Intent It is the policy of the facility to ensure that the resident receives Influenza and Pneumococcal immunizations, in accordance with State and Federal Regulations, and national guidelines. Procedure: .Pneumococcal Immunization . 5. Pneumococcal immunization will be offered in accordance with CDC immunization algorithm for PCV13 (13-valent pneumococcal conjugate vaccine) and PPSV23.</p>		