

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145844	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2024
NAME OF PROVIDER OR SUPPLIER Pearl of Montclare, The		STREET ADDRESS, CITY, STATE, ZIP CODE 2833 North Nordica Avenue Chicago, IL 60634	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45000</p> <p>Based on observation, interview, and record review, the facility failed to a.) monitor call light system and answer call lights within a timely manner for four residents (R1, R3, R4, R7), b.) failed to provide incontinence care for five (R1, R3, R4, R5, R6) dependent residents, c.) failed to ensure medications were administered as ordered by the residents' physician for one (R1) resident, and d.) failed to provide sufficient nursing coverage to ensure adequate resident care and support. These failures have the potential to affect 20 residents residing in the facility.</p> <p>Findings include:</p> <p>On 06/01/2024 at 9:35AM, R1 stated he is having on-going issues with the staff's call light response time. R1 stated on 06/01/2024 at approximately 2:00AM, R1 pressed his call light to have his incontinence briefs changed because he was soaked and soiled. R1 stated he waited so long to have his call light answered that he fell back to sleep. R1 stated he woke up at approximately 6:00AM and his call light was still on, and no staff member had come to his room to assist him with his needs. R1 stated he was still soiled at 6:00AM on 06/01/2024. R1 stated on 05/12/2024, he was not given his evening and night medications. R1 stated he was informed that he was not given his medications because there was not a nurse to administer them to him.</p> <p>On 06/01/2024 at 9:58AM, V4 (Certified Nursing assistant/CNA) stated she was scheduled to start her shift today on 06/01/2024 at 7:00AM. V4 stated she arrived at the facility at 6:50AM for her scheduled shift. V4 stated when she arrived there was not an off- going CNA present on the third floor north unit to give her report. V4 stated she was informed that the CNA who was assigned to care for residents on the third floor north unit from the previous 11PM-7AM shift (identified as V8) had already left the facility because V8 had to go to her next job. V4 stated she was informed that V8 left the facility at 6:00AM. V4 stated when she arrived and performed her rounds on the residents, R1's incontinence briefs were soiled. V4 stated R1 complained to her that V8 (CNA) never answered R1's call light and R1 had to wait until V4 came in to work to have his incontinence briefs changed.</p> <p>On 06/01/2024 at 10:06AM, R4 stated on 05/30/2024, R4 had to wait approximately 45 minutes to have his call light answered. R4 stated he has a colostomy bag and it ruptured and R4 needed staff assistance with cleaning R4 and replacing his colostomy bag. R4 stated he eventually called his brother to ask his brother to call the facility to get assistance. R4 stated his brother called him back and told him that he could not get in contact with anyone in the facility to help assist R4 with his needs. R4 stated he first pressed his call light on 05/30/2024 at 11:15AM and a staff member did not come to R4's room to assist R4 until approximately 12:00PM.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 145844	Facility ID: 145844 If continuation sheet Page 1 of 5

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/01/2024 at 10:15AM, R3 stated she is blind and needs staff assistance with her toileting needs. R3 stated she pressed her call light around 4AM this morning on 06/01/2024 and the assigned CNA (identified as V8) never came to answer R3's call light. R3 stated she was wringing wet and needed her incontinence briefs to be changed. R3 stated V3 (Licensed Practical Nurse/LPN) answered R3's call light and informed R3 that V8 (CNA) left the facility at 6:00AM. R3 stated she currently has her call light on, and it has been on for approximately one hour. R3 stated she pressed her call light because she must use the bathroom to be toileted. Surveyor located inside R3's room and observed a red light blinking on R3's call light system, no sound was audibly heard coming from the call light system. Outside of R3's room door a white light illuminated above R3's room door.</p> <p>On 06/01/2024 at 10:23AM, in the hallway on the three north unit R3's call light is observed still illuminated. Surveyor observed V4 (CNA) walk past R3's room but not answer R3's call light. At 10:26AM, V4 observed walking down the hallway past R3's room again and does not answer R3's call light.</p> <p>On 06/01/2024 at 10:27AM, V4 observed answering R3's call light and stated there is no sound that rings on the call light system, only the light illuminates.</p> <p>On 06/01/2024 at 10:28AM, V5 (CNA) stated the facility's call light system does not have an audible sound to alert staff that the resident's call light has been pressed. V5 stated there is only a light that illuminates above the resident's room when it is pressed. V5 stated this system allows the staff to constantly round on the residents to assist with resident's needs.</p> <p>On 06/01/2024 at 12:24PM, V2 (DON) stated she has been working at the facility since February 2024. V2 stated she learned in the second week of working at the facility that there is no sound for the facility's call light system. V2 stated there is only a light that illuminates when a resident presses their call light. V2 stated the facility staff taught her that the staff's call light protocol is to walk looking up to see the call light. V2 stated this is how the call lights are set up at the facility. V2 stated everyone is responsible for answering call lights even if they are not able to perform a specific task, they should answer the call light and refer the resident's needs to the appropriate person. V2 stated when agency staff work at the facility, there is a checklist that they sign off on acknowledging that the agency staff understands how the call light system works. V2 stated it is not okay to walk past a resident's illuminated call light unless it is an emergency. V2 stated she has not received any complaints of call lights not being answered in a timely manner since the end of February 2024. V2 stated nurses are allowed to administer medications one hour before and one hour after the scheduled administration times.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/02/2024 at 9:30PM, V7 (LPN) stated he was the nurse on duty on 05/31/2024 from 11PM-7AM on the third floor of the facility for this shift. V7 stated he was responsible for caring for residents on the three west unit and the three north unit. V7 stated there were two CNAs assigned on the third floor of the facility, one CNA assigned to the west unit and one CNA assigned to the north unit. V7 stated V8 (CNA) is an agency CNA whom he had never worked with before. V7 stated at the start of V8's shift, V8 informed V7 that V8 would be leaving the facility at 6AM in order to attend her next job. V7 stated he gave V8 her assignment and V8 was initially receptive and cooperative with her assignment. V7 stated later in the shift, V7 had a hard time locating V8 in the facility. V7 stated he observed V8 constantly on her phone during V8's assigned shift. V7 stated V8 would disappear off the unit and he did not know where V8 was located majority of the shift. V7 stated he observed multiple resident call lights illuminated throughout the shift. V7 stated he observed R1's call light illuminated also but he is unsure what R1's needs were because V7 did not get a chance to answer R1's call light. V7 stated he is not sure if R1's incontinence briefs were changed during the shift and could not answer R1's call light because V7 was administering medications to residents. V7 stated on 06/01/2024 at approximately 3:30AM, V7 was performing his medication administration pass and observed R7's call light illuminated. V7 stated he observed R7's call light illuminated for approximately 15 minutes. V7 stated this is the only facility he has ever worked for that has a silent call light system. V7 stated he does not feel the facility's call light system is an effective call light system for resident needs.</p> <p>V7 stated he then went to answer R7's call light and R7 stated he needed his incontinence briefs changed and needed some water. V7 stated he went to the third floor dining room to get water for R7 and observed V8 (CNA) sleeping in the dining room during her assigned shift. V7 stated when V4 (CNA) started her assigned shift on 06/01/2024 at approximately 7AM, V4 informed V7 that R5 and R6 were not changed, and their incontinence briefs were soiled. V7 stated once V8 left the facility at 6AM on 06/01/2024, no one was assigned to resume care for residents residing on the three north unit. V7 stated he did the best he could with answering resident call lights but V7 also had other nursing duties he was responsible for. V7 stated it is a problem if no one is assigned to care for residents and perform rounds on the residents because residents could potentially fall or be in distress if not monitored and rounded on. V7 stated when agency staff works at the facility, he encounters agency staff leaving the facility before their assigned shift is completed. V7 stated this happens approximately once or twice a month. V7 stated he has not encountered this behavior with regular staffing in the facility, only agency staff. V7 stated he has not informed anyone in management about the above occurrences and only gives report to the on-coming nurse when he completes his assigned shift.</p> <p>R1's Facesheet documents that R1 has diagnoses not limited to: secondary Parkinsonism, type 2 diabetes mellitus, heart failure, muscle weakness, need for assistance with personal care, reduced mobility, seizures, history of falling, urinary tract infection, and retention of urine.</p> <p>R1's Physician Order Sheet/POS documents in part the following orders:</p> <ol style="list-style-type: none"> 1. Ativan 0.5mg- Give 1 tab by mouth at bedtime 2. Atorvastatin 40mg- Give 1 tab by mouth one time a day 3. Brilinta 90mg- Give 1 tab by mouth two times a day 4. Budesonide-Formoterol Fumarate 160-4.5mcg/ACT- 2 puff inhale orally two times a day <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ol style="list-style-type: none"> 5. Buspirone 7.5mg- Give 1 tab by mouth three times a day 6. Carbidopa-Levodopa 25-250mg- Give 1 tab by mouth four times a day 7. Carvedilol 6.25mg- Give 1 tab by mouth two times a day 8. Entacapone 200mg- Give 1 tab by mouth four times a day 9. Hydroxyzine 25mg- Give 1 tab by mouth at bedtime 10. Ipratropium-Albuterol Inhalation Solution 0.5mg-2.5mg (3) mg/3ml- 3ml inhale orally every eight hours 11. Lantus 100unt/ml- Inject 10 unit subcutaneously at bedtime 12. Midodrine 5mg- Give 1 tab by mouth three times a day 13. Mirtazapine 45mg- Give 1 tab by mouth at bedtime 14. Novolog FlexPen 100unit/ml- Inject per sliding scale 15. Pramipexole Dihydrochloride 0.125mg- Give 1 tab by mouth three times a day 16. Sacubitril-Valsartan 24-26mg- Give 1 tab by mouth two times a day 17. Tamsulosin 0.4mg- Give 1 cap by mouth one time a day <p>R1's Medication Administration Audit Report reviewed for 05/12/2024 and documents that the above medications were not given as prescribed by the physician's orders.</p> <p>R1's MDS/Minimum Data Set, dated dated dated [DATE] documents that R1 is dependent with toileting hygiene needs. R1 has a Brief Interview for Mental Status/BIMS of 15/15, indicating that R1 is cognitively intact.</p> <p>R1's care plan documents in part, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Toileting: R1 requires one staff assistance with Toileting. Toileting Schedule: CNA to assist resident to the bathroom q2 hours while resident is awake.</p> <p>R3's Facesheet documents that R3 has diagnoses not limited to: Congestive heart failure, overactive bladder, anxiety disorder, Alzheimer's disease, dementia, legal blindness, polyarthritis, and left artificial hip joint.</p> <p>R3's MDS/Minimum Data Set, dated dated dated [DATE] documents that R3 requires partial/moderate assistance with toileting hygiene needs and is occasionally incontinent of bowel and bladder. R3's MDS documents that R3 has a Brief Interview for Mental Status/BIMS of 15/15, indicating that R3 is cognitively intact.</p> <p>(continued on next page)</p>		

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