STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145844	A. Building B. Wing	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Montclare, The	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)
F 0689 Level of Harm - 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** 15301 Based on interview and record review, the facility failed to utilize a gait belt during resident transfer, from toilet to wheelchair, for one of three residents (R1) reviewed for falls. This failure resulted in R1 falling and sustaining a left femur fracture. Findings include: Facility's incident report (Final of 7.13.2024) R1 is a [AGE] year-old on 8/13/2021. Diagnoses include Acute Systolic Congestive Heart Failure, Overactive Bladder, Hypertension, Anemia, Anxiety Disorder, Hyperlipidemia, Alzheimer Disease, Dementia Without Psychotic Disturbance, Legally Blind, and Polyarthritis. Patient is alert and oriented x3. Patient is legally blind and requires supervision with toileting/hygiene care, transfers, bed mobility, and ambulation with a rollator walker. Patient also utilizes a wheelchair for mobility as well. Patient is continent of both bladder and bowel. Patient was assisted to the bathroom on 7/8/24 by the nursing assistant with the use of a wheelchair. After the patient finished toileting and providing hygiene care to herself, she proceeded to wash her hands at the sink in the bathroom. The nursing assistant was standing in the doorway of the bathroom with the wheelchair and gave directions to the patient to stand up from the toilet seat and to take a step forward towards the sink, when all of a sudden patient got up and had a missed step while approaching the sink in front of her. There was a change in plane and patient fell on to her knees and then the patient leaned towards her left side resting her upper body against the wall. The nursing assistant informed the nurse. Patient was sent to the hospital via 911. According to hospital records patient sustained a left femur fracture and underwent a ORIF (Open Reduction Internal Fixation) of left femur on 7/10/24. R1's MDS (Minimum Data Set of 5/10/2024) documents R1 is severely visually impaired and is cognitively intact. R1's X-ray of hip (7/9/2024) documents: Comminuted fracture involving the distal femur which appears to extend to the articular surface distally is noted. 8/10/2024 at 9:53 AM, V9 (R1's son) said via telephone, R1 has had multiple falls; two within the last 30 days. R1 called V9, screaming in pain and told him she fell . V9 said R1 sustained a femur fracture. V9 said R1 is blind and would have never attempted to go to the bathroom on her own. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	8/10/2024 at 2:57 PM R1 awake/alert sitting up in bed eating pizza. Appears neat/clean. Surveyor asked R1 about her recent fall (7/8/2024). R1 said. I thought someone was with me (in the bathroom). Someone should be with me when I'm in the bathroom, I'm blind. I don't know if anyone helped me to the bathroom. Nobody was there when I fell . I go in the diaper now because I can't get up. R1 added, She kept hollering at me to sit down. I called my son; I told him I broke my hip. Call my son, he can tell you what happened. (Son was not at facility when resident fell). 8/10/2024 at 4:38 PM, V3 (LPN-Licensed Practical Nurse) via telephone said the CNA (Certified Nursing Assistant) told me R1 was on the floor in the bathroom. V3 stated, I went to bathroom; I saw the resident on the floor leaning against the wall. I asked the CNA what happened. She said the resident (R1) got up from the toilet, turned to sit down in the wheelchair and fell on the floor. The CNA told me she was standing behind the chair, holding the chair for the resident. She (CNA) said she (R1) could not move her leg. (R1) said she broke her leg. (R1) was unable to move her leg. We called 911, while I was waiting for 911, I (V3) did her (R1) assessment. I couldn't determine if she broke her leg. I asked R1 if she would be able to move her leg. I left her on the floor, 911 picked R1 up when they arrived and put her on the gurney. I forgot the CNA's name; I never saw her again. V3 insisted she left R1 on the floor while waiting for 911. I called the physician immediately but no there was no response. I was about to call the son; when he arrived at the facility; R1 called her son. 8/12/2024 1:35 PM, V5 (LPN-Licensed Practical Nurse) via telephone, said We use a gait belt with all the residents (when doing transfers); gait belts are part of their (CNA's) uniform. 8/12/2024 at 2:43 PM, V2 (DON) said, Yes, staff use gait belts. I don't remember if I asked her (V4) if she used a gait belt. (V4) was standing behind (R1)'s wheelchair. (V4) should have been in bathroom with (R1) and using gait belt. 8/12/2024 at 4:42 PM, V7 (Physical Therapist) via telephone, said R1 is legally blind, had a couple of falls, and requires a lot of cues. I evaluated her (after a fall), I don't exactly know how she fell , she was complaining of shoulder pain and couldn't lift her shoulder. (R1) is a contact guard assist (CGA) for transfers; hold her a little, use a gait belt. V7 added staff should use a gait when transferring R1. If a gait belt is not used (during transfers) the resident could fall with or without injury. V4 (CNA-Certified Nursing Assistant) was not available for interview. R1's Progress Note of 7/8/2024 at 15:22 (written by V3-Licensed Practical Nurse) Note Text: At 1300, the C. N.A came to the nursing station and reported, 'the resident fell in the bathroom'. On getting to the room noted the resident sat on the floor in front of the toilet seat and sink, leaned her back against the wall, straight the right leg and bent the right leg. The resident voiced, 'I broke my leg'. The resident is alert oriented x 3, able to make her needs known. The resident room and bathroom are clutter free and dry. There is adequate light in the room. Noted that the resident had shoes and socks on. The last time the writer saw the resident was during the lunch time at 12:00 p.m. Head to toe assessments were completed. Noted that the resident could not move nor stand on the leg. The resident still complained, 'I could not move my leg, I broke my leg'. The C. N.A assisted the resident to get up from the floor to the wheelchair and moved her to the side of the bed, then transferred her to the bed. The D.O.N. was made aware at 1307. Contact (resident's physician) with the order to send the resident out via 911. At 1307, the resident son was at the bedside at 1309. Called 911 @ 1354 and arrived at 1400 and transported the resident to the (local hospital).