| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145844 | A. Building<br>B. Wing | 03/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pearl of Montclare, The | 2833 North Nordica Avenue<br>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) |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>Based on interview and record review the facility failed to notify a physician and resident representative of a significant change in condition/status (newly identified deep tissue pressure injury) for one resident (R5). This failure affected 1 resident in the total sample of 3 residents reviewed for notification of changes. Findings include: R5 has diagnosis which include but are not limited to: cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery, dysphagia oropharyngeal phase, other lack of coordination, other reduced mobility, polycythemia vera, elevated white blood cell count, cerebral edema, type 2 diabetes mellitus without complications, unspecified protein calorie malnutrition, acute respiratory R5's Brief Interview for Mental Status (BIMS) dated 1/21/26 shows a score of 12 which indicated that R1 has moderate cognitive deficits. R5's progress note dated 1/19/26 at 11:30 am authored by V7 (Licensed Practical Nurse, LPN, Wound Care Nurse) documents, in part: PT (Physical Therapy) notified WCN (Wound Care Nurse) of skin condition to patients buttocks. On assessment, dtpi (Deep Tissue Pressure Injury) to sacral region. R5's Wound Summary dated 1/19/26 at 11:37 am, shows that R5 acquired a Deep Tissue Pressure Injury 1.20 cm x 0.40 cm with unknown depth. R5's Physician Order Sheet (POS) does not show orders for R5's sacral wound or management of R5's sacral wound. R5's Treatment Administration Record (TAR) dated January 2026 does not shows treatment for R5's sacral wound. On 2/25/26 1:02 pm, V7 (Licensed Practical Nurse, LPN, Wound Care Nurse) stated that on 1/19/26 the physical therapist who is now known as V16 (Occupational Therapist)) reported that R5 had a wound to his sacral area. V7 stated that she assessed R5's sacral wound and informed R5's physician of R5's sacral wound, however upon Surveyor and V7 review of R5's progress notes there was no family notification, physician notification or physicians orders implemented for R5's sacral deep tissue pressure (DTPI) injury wound. V7 stated that she did not carry out physicians orders for R5's sacral wound and stated, I must have forgot. V7 then explained that when a resident acquires a new wound the residents family and physicians must be notified and documentation of the conversation should be placed on a progress note in the residents medical record. V7 also explained if a resident's order for a wound is not implemented the resident's wound could worsen. On 2/25/26 at 3:00 pm, V16 (Occupational Therapist) stated that she was R5's Occupational therapist at the facility. V16 explained that she does not recall the exact date in question, however, she recalls when she was assisting R5 with care she observed R5 with a reddened spot to his tailbone area. V16 further explained that when she left from R5's room, V7 was standing in the hallway outside of R5's door and she immediately reported the skin breakdown to V7 who stated, I will take care of it (referring to R5's sacral wound). On 2/26/26 at 1:57 pm, V2 (Director of Nursing, DON) stated that she recalls R5 at the facility. V2 stated that she does not recall R5 having a wound at the facility. V2 explained that when a resident acquires a wound the nurse is made aware through the communication board, the wound care order from physicians orders for treatment of the wound, as well as a progress note regarding the residents change in condition assessment form. V2 also explained that when a resident acquires a wound the residents physicians and family should be notified regarding the residents change of condition and the conversation should be documented in the residents progress notes. V2 then explained if there is no<br>(continued on next page) |

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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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | order for a treatment for a residents wound the wound could deteriorate. The facility policy dated 10/09/2021 and titled Notification of Change in Condition, Discharge and Transfer documents, in part: Policy Statement: It is the policy of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate (hereafter designated as the physician). Procedure: 1. The nurse will immediately notify the resident, resident's physician and the resident representative(s) for the following (list is not all inclusive): .c. A need to alter treatment significantly (a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment. The nurse will notify the resident, resident's physician and the resident representative(s) for non-immediate changes of condition on the shift the change occurs unless otherwise directed by the physician . 3. Document the notification and record any new orders in the resident's medical record. 4. Educate the resident and/or representative about the proposed plan to treat, manage or monitor the resident's change in condition. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>Based on interview, and record reviewed the facility failed to ensure that a resident (R1) with a pressure ulcer received necessary treatment and services to promote healing. This failure affected one of three residents reviewed for wound care.Findings include:R5 has diagnosis which include but are not limited to: cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery, dysphagia oropharyngeal phase, other lack of coordination, other reduced mobility, polycythemia vera, elevated white blood cell count, cerebral edema, type 2 diabetes mellitus without complications, unspecified protein calorie malnutrition, acute respiratoryR5's Brief Interview for Mental Status (BIMS) dated 1/21/26 shows a score of 12 which indicated that R1 has moderate cognitive deficits.R5's Scale for Predicting Pressure Score Risk dated 12/10/25, 12/24/25, 1/1/26, and 1/6/26 shows that R5 is at risk for pressure ulcers. R5's progress note dated 1/19/26 at 11:30 am authored by V7 (Licensed Practical Nurse, LPN, Wound Care Nurse) documents, in part: PT (Physical Therapy) notified WCN (Wound Care Nurse) of skin condition to patients buttocks. On assessment, dtpi (Deep Tissue Pressure Injury) to sacral region.R5's Wound Summary dated 1/19/26 at 11:37 am, shows that R5 acquired a Deep Tissue Pressure Injury 1.20 cm x 0.40 cm with unknown depth.R5's Physician Order Sheet (POS) does not show orders for R5's sacral wound or management of R5's sacral wound.R5's Treatment Administration Record (TAR) dated January 2026 does not shows a treatment for R5's sacral wound. R5'S Care Plan Report does not show a problem statement (focus), measurable goals, or individualized interventions related to R5's sacral wound. On 2/25/26 at 12:37 pm, V8 (LPN) stated that she was R5's nurse prior to R5's discharge/transfer to the local hospital on 1/21/26. V8 explained that she only assessed R5's front side for skin alterations/breakdown and did not look at R5's buttocks stating that she could not turn R5 by herself. V8 stated that she was not aware of R5 having a wound to his sacral region.On 2/25/26 1:02 pm, V7 (Licensed Practical Nurse, LPN, Wound Care Nurse) stated that on 1/19/26 the physical therapist who is now known as V16 (Occupational Therapist)) reported that R5 had a wound to his sacral area. V7 then stated that she assessed R5's sacral wound and informed R5's physician of R5's sacral wound, however upon Surveyor and V7's review of R5's progress notes there was no family notification, physician notification or physicians orders implemented for R5's sacral deep tissue pressure (DTPI) injury wound identified on 01/19/26. V7 further explained that she did not carry out physicians orders for R5's sacral wound and stated, I must have forgot. V7 then explained that when a resident acquires a new wound the residents family and physician must be notified and the documentation of the conversation should be placed on a progress note in the residents medical record. V7 also explained if a residents orders for a wound is not implemented the residents wound could worsen. On 2/25/26 at 3:00 pm, V16 (Occupational Therapist) stated that she was R5's Occupational therapist at the facility. V16 explained that she does not recall the exact date in question however, she recalls when she was assisting R5 with morning care she observed R5 with a reddened spot to his tailbone area. V16 further explained after she observed R5's reddened tailbone, she immediately informed V7, who was standing in the hallway outside of R5's door. V16 explained that V7 stated, I will take care of it (referring to R5's sacral wound).On 2/26/26 at 1:57 pm, V2 (Director of Nursing, DON) stated that she recalls R5 at the facility and explained that she does not recall R5 having a wound at the facility. V2 explained that when a resident acquires a wound the nurse(s) are made aware through the communication board, the wound care order from physicians orders for treatment of the wound, a progress note regarding the residents change in condition is documented and an assessment form is completed. V2 also explained that when a resident acquires a wound the residents physicians and family should be notified regarding the residents change of condition and the conversation should be documented in the residents progress notes. V2 then explained if there is no order for a treatment for a residents wound the wound could deteriorate. The facility policy dated 10/09/2021 and titled Wound Prevention and Healing documents, in part: Policy<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Statement: To provide wound care treatment/services (using a multidisciplinary approach) based on evidence-based standards of care under the direction of a physician. 1. b. Braden scale will be completed to determine the patient's level of Risk and implement interventions to prevent development of pressure injuries. 10. Home care and treatments: a. Warm care treatments are provided within an individualized plan of care under the direction of a physician. 11. The multidisciplinary wound care team: 1. The wound care team is responsible for identifying problems, coordinating care, and promoting development of the team and the program. 2. Certify wound care nurses and trained nurses are responsible for oversight of wound care rendered to all wound care patients, including the patient assessments, evaluation treatment regimens, plans of care, care outcomes, and cost effective of the treatment plan of care. |