

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145946	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2024
NAME OF PROVIDER OR SUPPLIER Pearl of Hillside,the		STREET ADDRESS, CITY, STATE, ZIP CODE 4600 North Frontage Road Hillside, IL 60162	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41156</p> <p>Based on interview and record review, the facility failed to supervise/monitor resident during smoke break. This affected one of three residents (R1) reviewed for monitoring and supervision. This failure resulted in R1 having a face forward fall sustaining an open fracture of nasal bone and a nasal laceration requiring four sutures.</p> <p>Findings Include:</p> <p>R1 was admitted with Schizophrenia, Dementia with behavioral disturbance, restlessness, agitation and generalized anxiety. Brief interview for mental status dated 2/8/24 documents a score of six out of fifteen which indicates severe cognitive impairment. Fall assessment dated [DATE] documents: high risk for falls with a score of 17.0.</p> <p>On 7/27/24 at 2:56PM, V5 (ADON) said, V7 (nurse) took R1 to smoke. V7 is not a smoker. V7 stepped one arm length away from R1 while R1 was smoking. R1 dropped his cigarette, reached down to pick it up and fell face forward out of his wheel chair. V7 could not reach R1 before his fall. R1 sustained a fractured nose. V5 said, R1 has poor safety awareness related to his impulsiveness but he is able to comprehend. R1 was given a Reacher after his first fall</p> <p>On 7/27/24 at 1:35PM. V7 (nurse) said, he took R1 to smoke. V7 said, he was not at smoker. V7 said, he stood inside the entrance/exit smoking patio door monitoring, looking and checking on R1 via the opened door. V7 said, R1 was on the patio just pass the call bell sitting at the table and he stood inside the door. V7 said, the door and where R1 was sitting was one to two steps away. V7 said, he saw R1 bending and picking up something from the floor. V7 said, he attempted to reach out and grab R1 but R1 was on the floor already. V7 said, he was able to grab R1's jacket which slid off.</p> <p>On 7/27/24 at 2:21 PM, State Surveyor along with V2 (DON) measured the distance between the smoke patio door and the resident outside call bell to be seven feet and seven inched apart.</p> <p>On 7/27/24 at 2:45PM, V2 (DON) said, the patio is concrete.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Nursing note dated 3/26/24 documents: R1 was noted reaching forward for his cigarette on the floor. R1 was noted falling face forward from his chair. Writers tried to hold on to the resident jacket to prevent him from hitting the floor. R1 moved too fast. R1 was on the floor with abrasion to his left fore head and sustained an injury to his nose bridge. Fall event dated 3/26/2024 documents: Smoking Area: The resident stated, he was trying to pick up his cigarette from the floor and fell out of the chair.</p> <p>Health care note dated 3/27/24 documents: IDT (interdisciplinary team) met to discuss resident's recent fall, R1 was attempting to reach for something on the ground while on the smoke patio and slid from his chair, staff unable to assist him however was there to supervise smoke time, R1 unaware of safety boundaries and is impulsive, he is instructed to ask staff for assistance and Reacher given to R1. Health care note dated 4/7/24 documents: R1was noted reaching forward for his cigarette on the floor and fell out the chair.</p> <p>Health care note dated 3/29/24 documents: Resident remains on PO ABT (by mouth antibiotic) therapy for open fracture of nasal bone.</p> <p>Health care note dated 4/7/24 documents: R1 was noted reaching forward for his cigarette on the floor and fell out the chair.</p> <p>Health care note dated 4/12/24 documents: IDT team met to discuss resident's recent fall, resident was attempting to reach for something in front of him and slid out of the chair, staff able to assist him back to his chair, resident unaware of safety boundaries, he is instructed to allow staff to assist him when items are needed off of the floor continues to educate to utilize Reacher to aide resident.</p> <p>On 7/27/24 at 1:25PM V9 (nurse) said, V9 educated the agency staff (CNA) who took R1 to smoke to stay within arm's length of R1. The agency staff personnel reported to V9 that R1 dropped his cigarette, reached for it and fell before the agency staff could reach R1. R1 kept his Reacher on the side of his wheelchair. V9 also stated that R1 was able to use the Reacher at the point of education but forgets. R1 said, he forgot to use the Reacher after his second fall.</p> <p>MDS (Minimum Date Set) assessment dated [DATE] shows that R1 has a BIMS (Brief Interview for Mental Status) score of 6 which means severe cognitive impairment prior to R1's first fall on 3/26/24.</p> <p>Hospital record dated 3/27/24 reads in part: Clinical impression: Open fracture of nasal bone, initial encounter. Facial laceration, initial encounter. Injury of head, initial encounter. Physical exam: Head 2cm vertical laceration noted over the bridge of the nose. Slightly gaping laceration. Tenderness to palpitation to bilateral maxillary areas. The wound repaired with 6-0 nylon sutures x 4. Hospital discharged medication clindamycin 300mg by mouth three times daily for 7 days.</p> <p>Fall Prevention and Management policy with a revised date of 4/8/24, reads in part: The facility is committed to its duty of care to residents and patients in reducing risk, the number and consequences of falls including those resulting harm and ensuring that a safe patient environment is maintained.</p> <p>All residents and patients will be considered at risk for falling, regardless of fall risk score. Universal fall precaution (facility protocol) interventions will be implemented to all.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>High Risk residents and patients for fall will receive individualized intervention appropriate to risk factors.</p> <p>Development of the fall interventions plan is based on results of the Falls Assessment as well as investigation of all circumstances and related resident outcomes. Include multidisciplinary discussion of interventions that did not work in the past and is currently effective at the moment. Adjust care plan after careful review. If necessary, fall assessment and fall interventions will be reviewed, revised and update as necessary.</p>		