STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145980	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of St Charles, The	850 Dunham Rd St Charles, IL 60174

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488 Based on interview and record review the facility failed to ensure a resident was cared for in a dignified manner for 1 of 3 residents (R6) reviewed for dignity in the sample of 16. The findings include: R6's face sheet showed she was admitted to the facility on [DATE] with diagnoses to include epilepsy, malignant neoplasm of brain, hemiplegia and hemiparesis following cerebral infarction, malignant neoplasm of right female breast, and malignant neoplasm of left female breast. R6's facility assessment dated [DATE] showed she has no cognitive impairment and is dependent on staff for showers. R6's care plan initiated 2/2/24 showed, The resident has an ADL self-care performance deficit needs and participation may vary related to weakness and multiple medical comorbidities . On 4/23/24 at 12:18 PM, R6 said a few weeks ago she had some issues during a shower. R6 said she was in the shower and the CNA (Certified Nursing Assistant) who was assisting her had ear buds in her ears. R6 said the CNA was having a conversation with someone and she could hear it was a male's voice on the phone. R6 said she felt like she was interrupting the CNA's conversation with whoever was on the phone with her to try and tell her what soap she uses. R6 said she was uncomfortable being naked and hearing a male's voice. R6 said she asked the CNA where her phone was, and she said it was laying over on the counter. R6 said she was worried if the phone was lying flat or could have been propped up. R6 said, I told her I was uncomfortable because I was naked, and I thought he could be looking at me for all I know. R6 said the CNA just kept talking on the phone. The facility's grievance binder showed R6 filed a grievance on 4/1/24 related to a CNA on her cell phone in the shower room while providing direct cares. The grievance showed, . Resolution . Phones are not allowed during caregiving . On 4/24/24 at 12:01 PM, V1 (Administrator) said the CNA who was assisting R6 in the shower while using her cell phone was V15. On 4/24/24 at 12:08 PM, V8 (CNA) said staff are not to be using cell phones while providing cares. V8 said staff should be using a cell phone while assisting with a shower because the resident could think you are taking pictures and it could be a privacy issue. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145980	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024

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Pearl of St Charles, The	850 Dunham Rd St Charles, IL 60174

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/24 at 12:30 PM, V16 (Restorative Nurse/Nurse Manager) said staff are not to be on their cell phones while providing care for privacy and dignity reasons for the residents. The Residents' Rights for People in Long-term Care Facilities booklet showed, . You have the right to safety and good care. Your facility must provide services to keep your physical and mental health, and sense of satisfaction . The facility's employee handbook showed, Cell Phone/Personal Calls, Camera/Video . Cell phone usage is not permitted during working hours in any resident care or common areas Earpieces are not to be worn during working hours .

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F 0580 Level of Harm - Minimal harm or potential for actual harm 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. 41639 Based on interview and record review, the facility failed to notify a resident's (R1) Power of Attorney (POA) for a change in medical condition for 1 of 3 residents reviewed for change in condition in the sample of 16. The findings include: R1's electronic face sheet printed on 4/25/24 showed R1 had diagnoses including but not limited to acute on chronic congestive heart failure, chronic respiratory failure with hypoxia, end stage renal disease, and pleural effusion. R1's progress notes dated 4/11/24 showed, Around 1AM, CNA (Certified Nursing Assistant) made writer aware that resident complained of shortness of breath, even with oxygen on at 2L/min. Oxygen was 77%, blood pressure 122/69, pulse 70, clear lung sounds. Called physician and received orders to increase oxygen to 5L/min to keep oxygen saturations above 90%. Resident's oxygen improved to 86%. Bumex 2mg to be given. Tablet given at 2:16AM. STAT chest x-ray and STAT BNP/CMP (b-type natriuretic peptide/comprehensive metabolic panel) to be completed. Orders placed. R1's nursing progress notes from 4/9/24-4/11/24 were reviewed and showed no documentation that R1's POA was notified of her change in condition until approximately 1:30PM on 4/11/24. (12 hours after her change in condition began) On 4/25/24 at 12:01PM, V20 (Registered Nurse) stated, R1's change in condition started during my shift during the early morning hours on 4/11/24. I didn't notify her POA because we got her back stabilized as much as we could until we could get labs back. We are supposed to notify a resident's POA when any condition or treatment change occurs, but I guess I didn't think about it because we kind of had her back at baseline. (R1 was sent to the hospital on 4/11/24 for respiratory failure at approximately 3:45PM) On 4/25/24 at 12:14PM, V16 (Restorative Nurse-Manager on Duty) stated, The nurses should be letting family members know as soon as there is a condition or treatment change for a resident. There are certain times where the notification could wait in the middle of the night, but this is not one of those cases. There's no reason why (V20) shouldn't have notified (R1's) POA in this situation. The facility's policy titled, Resident Change in Condition Notification reviewed 12/18/23 showed, 2. Regardless of the resident's current mental, medical, or physical condition, a nurse or healthcare provider will inform the resident and resident's representative/guardian of any changes in his/her condition, any incident or accident, including changes in medical care or nursing treatments.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488 Based on interview and record review the facility failed to ensure activities of daily of living were provided for a resident dependent on staff for cares for 1 of 3 residents (R6) reviewed for activities of daily living in the sample of 16. The findings include: R6's face sheet showed she was admitted to the facility on [DATE] with diagnoses to include epilepsy, malignant neoplasm of brain, hemiplegia and hemiparesis following cerebral infarction, malignant neoplasm of right female breast, and malignant neoplasm of left female breast. R6's facility assessment dated [DATE] showed she has no cognitive impairment and is dependent on staff for showers. R6's care plan initiated 2/2/24 showed, The resident has an ADL self-care performance deficit needs and participation may vary related to weakness and multiple medical comorbidities . On 4/23/24 at 12:18 PM, R6 said she has issue with staff on the weekends. R6 said this previous weekend she was not assisted to get dressed, get out of bed, or brush her teeth on Saturday (4/20/24) and was not assisted to get out of bed on Sunday (4/21/24). R6 said the staff tell her they are short staffed and can't get her into her wheelchair without two people since she requires a mechanical lift for transfers. R6 said she is supposed to assisted up into the chair every day for at least a couple of hours. On 4/24/24 at 12:08 PM, V8 (Certified Nursing Assistant/CNA) said R6 requires assistance to get changed, turn, and reposition, brush her teeth, do her hair, and get up from bed. V8 said R6 requires a mechanical lift to transfer from her bed. V8 said R6 is alert and oriented. V8 said R6 usually get up out of bed after breakfast for a few hours but likes to be back in bed before 3 PM. V8 said on Saturday (4/20/24) there was an agency CNA that left part of the way through first shift and the CNA assignments were shifted around. V8 said she endorsed to the oncoming CNA (V9) that R6 wanted to be assisted and to call her when she was ready to transfer her out of bed. V8 said she was never asked to come assist in getting R6 out of bed on Saturday. On 4/24/24 at 1:04 PM, V9 (CNA) said worked Saturday (4/20/24) and one of the CNAs left and someone called off. V9 said there are times that this happens, and she is unable to get all her tasks done such as giving showers and sometimes has to leave people in bed. V9 said she never got R6 up on Saturday. V9 said Saturday was the first day R6 asked her to get her up. V9 said they can't get R6 up and down when they have to be feeding people, doing smoke breaks and assisting other residents. ON 4/24/24 at 1:30 PM, V12 (Registered Nurse) said it was brought to his attention on Saturday that R6 wanted to get out of bed it was later in the day and R6 said she no longer wanted to get up. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/24 at 12:30 PM, V16 (Restorative Nurse) said R6 likes to get out of bed but does want to be the one to determine when she gets up because she does not like to be up all day. V16 said it is not acceptable to leave R6 in bed. V16 said she expects the staff to get R6 up, dressed, and set up for brushing her teeth daily. V16 there is always someone at the facility to help with transfers with the mechanical lifts and it is unacceptable to tell the resident they cannot get up because there is no one to help transfer. The facility's policy and procedure reviewed 12/5/23 showed, . Policy: Supporting Activities of Daily Living . Policy Statement: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene .

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F 0689 Level of Harm - Minimal harm or potential for 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** 41639 Based on observation, interview, and record review the facility failed to use a gait belt while transferring a resident, failed to re-evaluate interventions put in place for a resident identified as an elopement risk. These failures apply to 1 of 3 (R3) residents reviewed for safety/supervision in the sample of 16. The findings include: 1) R3's electronic face sheet printed on 4/25/24 showed R3 has diagnoses including but not limited to senile degeneration of the brain, dementia with behaviors, overactive bladder, and primary generalized osteoarthritis. R3's facility assessment dated [DATE] showed R3 has severe cognitive impairment and has no wandering behaviors. R3's care plan dated 11/20/23 showed, The resident is an elopement risk/wandered related to dementia, confusion, impaired safety awareness, agitation, wandering, looking to keep busy, resident able to propel wheelchair around facility, residents is noted to attempt pushing exit doors. Resident is noted to wander into other resident rooms. R3's elopement risk review dated 2/12/24 showed R1 is a high risk for elopement due to memory problems, history of purposeful exit seeking, history of grasping at doorknobs, handles or following visitors closely, moves about the facility independently, and has exhibited exit-seeking behaviors. R3's nursing progress notes were reviewed from 10/30/23-4/25/24 and showed R3 had 9 documented instances where she opened or attempted to open exit doors to leave the facility. 3 of the above instances documented R3 had attempted to exit the facility multiple times on a shift. On 4/23/24 at 12:34PM, Surveyor was unable to find R3 in her room, in the dining room, or on any nursing unit. Surveyor asked V8 (Certified Nursing Assistant/CNA) if she knew where R3 was located. V8 stated, I just saw her not that long ago. She is all over this place so we try to keep an eye on her the best we can. V8 then began searching the building for R3 and a Code Yellow was called over the loudspeaker to locate R3. Staff were able to locate her within a short amount of time in another resident's room. On 4/24/24 at 10:45AM, V5 (R3's daughter) stated, They redirect my mom as much as they can and that usually works so she doesn't try to leave. She wants to go home. I don't think she would actually ever leave the facility, but she sure does try a lot. The only intervention that they have told me about is just to keep an eye on her and redirect her when they see her at the doors. Other than that, there's not much else they are doing but I'm not sure what else can be done. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/24 at 12:09PM, R3 wheeled herself down the hallway towards the exit door. R3 looked at the door and then turned around and went into R14's room. R14 immediately began screaming Hey! Get the he** out of here! Get this motherf***** out of my room NOW! Staff immediately responded and removed R3 from R14's room. On 4/25/24 at 12:20PM, V8 (CNA) stated, It's a group effort to keep an eye on (R3) but when she's on my assignment I try to at least visualize her every hour. If I am busy, then I ask someone else to locate her for me. Nine times out of 10 when we can't find her, she is either trying to go to the bathroom or trying to go out one of the doors. On 4/25/24 at 1:29PM, R14 stated, That lady comes in my room all the time and it's terrible. It scares me when she comes in my room and I'm sleeping. Earlier she came in and I was sleeping and when I woke up, she was right next to my bed, so I screamed for help. She comes in so fast in her wheelchair I never know what she's going to do, and I can't get up on my own. I don't know if she's going to come at me and hit me or what. On 4/25/24 at 10:57AM, V19 (Registered Nurse) stated, (R3) is all over this facility. She goes into other resident rooms a lot and is always pushing on the exit doors. We monitor her, offer hydration and toileting but those are the only interventions that I am aware of. On 4/25/24 at 12:14PM, V16 (Restorative Nurse-Manager on Duty) stated, (R3) is constantly up and down the hallways and in everyone's room. Her family doesn't want to move her to a specialized facility and wants to keep her here. If we can't find her, we call a code yellow and she's usually in someone's room. She does that a lot and other resident's get upset about it. We have never used any type of electronic monitoring or anything so I'm not sure why that's even in our policy. We try to keep an eye on her, but we don't have a set time frame of how often we check on her. If someone is looking for her, we typically just call a code yellow. I agree we should have a better plan for her, but I just don't know what else we could do. The facility's policy titled, Elopement, Risk Reduction Strategies, and Management of Missing Residents reviewed on 1/18/23 showed, 'The facility strives to promote resident safety and protect the rights and dignity of the residents. The facility maintains a good process to assess all residents for risk of elopement, implement risk reduction strategies for those identified as an elopement risk, institute measures for resident identification at the time of admission, and conduct a coordinated resident search in the event of a missing resident .Elopers are different from wanderers by their overt, and often repeated attempts to leave the facility and premises .B. Risk Reduction Measures. 1. Interventions that may be used for residents identified as high risk for elopement include: a. frequent monitoring of the resident's whereabouts to assure he or she remains in the facility (e.g. every 30 min checks) .e. Implementation of wander bracelet or other electronic alert systems. 2) R3's facility assessment dated [DATE] showed R3 requires partial/moderate assistance for transfers. R3's fall risk assessment dated [DATE] showed R3 is a moderate risk for falls due to multiple falls within the past 6 months. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's care plan dated 5/3/21 showed, Resident is at risk for falls. The resident has impaired cognition and impaired safety awareness. The resident has balance or walking impairments. The resident has a history of falls. The resident takes medications that may cause dizziness, loss of balance, or impair judgement. On 4/24/24 at 12:39PM, V6 (Certified Nursing Assistant) provided toileting assistance to R3. V6 placed R3 in front of the grab bar in the bathroom, lifted her up by her left arm and assisted her over to the toilet. V6 then assisted R3 off the toilet by her right arm and assisted her back to her wheelchair. V6 did not use a gait belt during this transfer and stated, I don't really think she needs one. There are gait belts in all resident rooms, but I don't think she's one that requires it. On 4/25/24 at 12:14PM, V16 (Restorative Nurse) stated, Any resident that needs any type of assistance with transfers should have a gait belt on them during a transfer for both their safety and the staff member's safety. If the resident were to fall, the gait belt is a good way to for staff to be able to lower them gently or catch them before they fall. The facility's policy titled, Gait Belts dated 11/1/18 showed, Gait belts are used to help to prevent injury of staff or residents during transfers or ambulation. Guideline: 1. Gait belts should be used by all staff when ambulation or transferring a resident.