STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **0058461**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/24/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ELGIN, THE	**2355 ROYAL BOULEVARD , ELGIN, Illinois, 60123**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Annual Licensure Survey	S0000		08/06/2025
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1010h) 300.1210b) 300.1210d)2) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and	S9999		08/06/2025

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

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S9999	Continued from page 1 Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following 2) All treatments and procedures shall be administered as ordered by the physician. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident received a scheduled hemodialysis treatment by arranging transportation to the dialysis center. This failure resulted in R66 missing a scheduled hemodialysis appointment and being hospitalized in the Intensive Care Unit for an elevated potassium level and requiring urgent hemodialysis. This applies to 1 of 1 resident (R66) reviewed for hemodialysis in the sample of 24. The findings included: The EMR (Electronic Medical Record) showed R66 was admitted to the facility on March 6, 2025, with multiple diagnoses including end stage renal disease, hyperkalemia, and type 2 diabetes mellitus. R66's hemodialysis care plan dated April 22, 2025, showed "The resident needs dialysis (hemodialysis) related to end stage renal disease." The care plan continued to show multiple interventions dated April 22, 2025, including "Encourage resident to go for scheduled dialysis appointments. Resident receives dialysis." R66's Order Audit Report dated July 23, 2025, showed an order dated May 6, 2025, for "Hemodialysis: [Dialysis Center], Every Tuesday, Thursday, Saturday." A progress note dated June 14, 2025, at 12:51 PM, by V12 (LPN/Licensed Practical Nurse) showed "Resident missed dialysis session scheduled for today at 9:30 due to transportation not covered under resident's insurance. Per daughter, she is out of town and cannot take resident to dialysis. Resident's son called by [dialysis center] nurse but no answer. Per [dialysis center] nurse resident's dialysis rescheduled for Monday, 6/16/25 at 2:30 PM. Per [dialysis center] if	S9999		

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S9999	Continued from page 2 there is a change in condition with resident, resident to be sent out to the hospital. [V20 (Nurse Practitioner)], nephrologist, and administrator all made aware of situation." A progress note dated June 15, 2025, at 6:27 PM, by V21 (LPN/Licensed Practical Nurse) showed "resident noted in bed confused and lethargic. Family member at bedside and worried. Vital signs, blood pressure 185/88, respiratory rate 20, pulse rate 71, temperature 98.9, oxygen saturation 93% (percent) on room air. Resident missed her scheduled dialysis yesterday. There is a standing order to send the resident to emergency room if the condition gets worse. Called up 911, paramedics came in less than five minutes after. Resident was transported to [local hospital] emergency room for evaluation. [V20], Director of Nursing, and daughter were made aware." On July 23, 2025, at 12:25 PM, V12 said she was caring for R66 on June 14, 2025. V12 said R66 had scheduled hemodialysis on June 14, and transportation usually showed up around 9:30 AM, but they did not show up that day. V12 said when transportation did not show up, V12 called the transportation company and was told R66's insurance stopped covering after June 2, 2025. V12 said she was unaware R66 did not have coverage for her transportation that day. V12 said she notified V20 and V20 told V12 to notify R66's nephrologist that R66 missed her scheduled hemodialysis. V12 said she called the nephrology office and left a message for the on-call provider, but V12 never received a call back from the nephrologist. On July 23, 2025, at 12:13 PM, V14 (Transportation Coordinator) said she arranges for R66's transportation for hemodialysis. V14 said the facility pays for R66's transportation for hemodialysis. V14 said on June 14, 2025, transportation did not show up to take R66 to hemodialysis and when V14 called the transportation company, they told V14 they were running behind and to give them a couple hours. V14 said the transportation company never showed up. V14 said there was supposed to be a scheduled appointment for R66 to be transported to hemodialysis on Tuesday, Thursdays, and Saturdays. On July 23, 2025, at 1:22 PM, V16 (Transportation Company Dispatch Supervisor) said R66's original standing order for transportation appointments to hemodialysis for Tuesdays, Thursdays, and Saturdays, was started on May 13, 2025. V16 said starting June 2, 2025, V14 stopped the standing order for appointments. V16 said V14 arranged for three more transportation appointments for R66 on June 7, June 10, and June 12,	S9999		

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S9999	Continued from page 3 2025. V16 said the transportation company never received a request for transportation for R66 on June 14, 2025. V16 said since an appointment was not arranged on June 14, the transport company would not go to the facility to pick up R66. On July 23, 2025, at 4:29 PM, V3 (ADON/Assistant Director of Nursing) said the facility uses a second transportation company and it is possible the appointment was scheduled with that company. V3 called the other transportation company and spoke with a representative from the company. V3 said the transportation company representative said they did not have an appointment for R66 to be transported to the dialysis center on June 14, 2025. V3 said R66 should not have missed her scheduled hemodialysis appointment because transportation should have been arranged. R66's hospital progress note dated June 16, 2025, at 7:13 AM, by V22 (Critical Care Nurse Practitioner) showed "…Laboratory results showed hyperkalemia with potassium of 6.8 (normal potassium is 3.6-5.0). [R66] missed her dialysis yesterday because insurance wouldn't pay for transportation and family couldn't arrange for it. She did receive dialysis on Thursday without issues. Potassium shifters were administered in the emergency department. Nephrology requested emergent dialysis, so Intensive Care Unit is being consulted for admission… Assessment/Plan: [R66] is a 73-year-old with a history of type 2 diabetes mellitus, end stage renal disease on hemodialysis (Tuesdays, Thursdays, and Saturdays), hypothyroidism, hypertension, dementia who is being admitted for acute hyperkalemia with hypertension emergency/altered mental status in setting of missed dialysis. Problems: hypertension emergency with altered mental status, acute hyperkalemia due to missed dialysis… Emergent hemodialysis overnight with two liters ultrafiltration, will resume hemodialysis on normal Tuesday, Thursday, Saturday schedule…" On July 24, 2025, at 9:36 AM, V20 (R66's Nurse Practitioner) said she was notified on June 14, 2025, that R66 missed hemodialysis due to a mix up with R66's transportation. V20 said she was worried since R66 missed hemodialysis she would have elevated toxins in her blood. V20 said she informed V12 to notify R66's nephrologist about the missed hemodialysis treatment. V20 said she was not informed V12 did not speak to R66's nephrologist. V20 said R66's potassium level of 6.8 was caused from R66 missing her scheduled hemodialysis treatment. V20 said a potassium level over 6 needs to be treated right away because it can cause life threatening cardiac arrythmias. V20 said since R66 is dependent on hemodialysis, hemodialysis is how to	S9999		

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S9999	Continued from page 4 treat R66's elevated potassium level. V20 said it is her expectation the facility arranges for transportation so R66 does not miss a scheduled hemodialysis appointment. The facility's policy titled "Appointments and Transportation" dated April 16, 2025, showed "Policy Statement: When a resident has an appointment outside of the facility, the staff will make the transportation arrangements, unless the responsible party chooses to make the arrangement themselves. (A) 2 of 2 300.615 f) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information. f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. The REQUIREMENT was not met as evidenced by: Based on interview and record review, the facility failed to ensure that Illinois Department of Corrections (IDOC) Sex Registrant searches were completed for admitted residents. This applies to 10 of 10 residents (R134, R130, R135, R136, R133, R4, R27, R52, R115, and R34) reviewed for criminal background checks in the sample of 24. The findings include: 1. R134's EMR (Electronic Medical Record) showed that R134 was admitted to the facility on July 18, 2025. 2. R130's EMR showed that R130 was admitted to the facility on July 17, 2025. 3. R135's EMR showed that R135 was admitted to the facility on July 14, 2025. 4. R136's EMR showed that R136 was admitted to the facility on July 14, 2025. 5. R133's EMR showed that R133 was admitted to the facility on March 24, 2025.	S9999		

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S9999	Continued from page 5 6. R4's EMR showed that R4 was admitted to the facility on January 28, 2025. 7. R27's EMR showed that R27 was admitted to the facility on May 13, 2025 8. R52's EMR showed that R52 was admitted to the facility on February 25, 2025. 9. R115's EMR showed that R115 was admitted to the facility on June 27, 2025. 10. R34's EMR showed that R34 was admitted to the facility on May 29, 2025. On July 23, 2025 at 3:29 PM, V5 (Admissions Director) stated she is responsible for completing background checks on all admitted residents. V5 also stated that she has never checked any residents on the IDOC sex registrant search page. V5 stated that resident background checks are done to ensure residents don't hurt themselves and others and to keep residents and staff in the facility safe. As of July 23, 2025 at 3:29 PM, the facility did not have any documentation to show that R134, R130, R135, R136, R133, R4, R27, R52, R115, and R131 names were checked on the IDOC Sex Registrant search page. (C)	S9999		

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S9999		S9999		

On July 23, 2025 at 3:29 PM, V5 (Admissions Director) stated she is responsible for completing background checks on all admitted residents. V5 also stated that CHIRP's should be completed within 24 hours of admission on all residents. V5 stated that resident

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S9999	Continued from page 7 background checks are done to ensure residents don't hurt themselves and others and to keep residents and staff in the facility safe.	S9999		