

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145045	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/06/2024
NAME OF PROVIDER OR SUPPLIER Pearl of Naperville, The		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Martin Avenue Naperville, IL 60540	

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15845</p> <p>Based on interview and record review, the facility failed to investigate and report an allegation of potential abuse/neglect. This applies to 1 of 6 residents (R1) reviewed for potential abuse/neglect in the sample of 10.</p> <p>The findings include:</p> <p>The EMR (Electronic Medical Record) showed R1 is a [AGE] year-old with diagnoses of ALS (amyotrophic lateral sclerosis), gastroenteritis, colitis, epilepsy, BPH (benign prostatic hypertrophy), and lack of coordination. R1 was admitted to the facility on [DATE].</p> <p>The MDS (Minimum Data Set), dated August 24,2024, showed R1 was cognitively intact with BIMS (Brief Interview Mental Status) score of 15/15. The MDS also showed R1 requires substantial assistance from staff for ADL (Activities of Daily Living) including oral care, hygiene, and grooming.</p> <p>On September 30,2024 at 12:36 P.M., R1 stated V9 (CNA, Certified Nurse Assistant from staffing agency) was very rude and had refused to give care when asked. R1 stated this was reported immediately to (V4, ADON/Assistant Director of Nursing) and to (V16, scheduler/MOD/manager on duty) on September 25,2024.</p> <p>V16 said on September 25,2024, sometime during the day shift, R1 had reported to her V9 was rude and refused to help brush R1's teeth. V16 said she made sure V4 was made aware of the complaint from R1.</p> <p>On September 30,2024 at 1:10 P.M., V1 (Administrator) stated he was off for a week, including the time R1 had reported the allegation. V1 added V2 (Regional Operation Manager) was the designated designee as the Administrator and Abuse Task Coordinator in V1's absence. V1 added he had not received any report of alleged abuse from V2 when he returned to work. V1 said there was no investigation conducted regarding this allegation from R1.</p> <p>On September 30,2024 at 1:15 P.M., V2 was interviewed, and confirmed she was the designee administrator and abuse task coordinator when V1 was away for a week. V2 also said on September 25, 2024, V2 was the designee as the abuse task coordinator. V2 said she was never informed by any staff including (V4, V3-interim DON and V16) regarding (R1's) allegation.</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On September 30,2024 at 1:20 P.M., V4 was interviewed via phone with V1 present. V4 said, I remember that (R1) had complained about his nutritional supplement and medications not available and there were no other complaints. I wrote this in the grievance form on September 25,2024. V4 then added she remembered R1 had complained V9 was rude and refused to brush (R1's) teeth. V4 added she reported R1's complaint to V3 and V2, and was advised to document a customer service report.</p> <p>The facility's Abuse policy, dated September 5,2024, showed:</p> <p>NEGLECT .Regardless of the specific nature of the allegation (physical, sexual, verbal/mental abuse, theft, neglect, unreasonable confinement/involuntary seclusion, or exploitation), the investigation shall consist of:</p> <p>-Completion of a written report on the status of the investigation within 24 hours of the occurrence or as soon as possible, but no more than 2 hours.</p> <p>The Facility's undated policy for Abuse showed:</p> <p>Residents have the right to be free from abuse, neglect Neglect is a facility's failure to provide, or willful withholding of adequate personal care or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish and mental illness of a resident .Employees are required to report any allegation of potential abuse, neglect that they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator. In the absence of the administrator, reporting can be made to an individual who has been designated to act in the administrator's absence.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15845</p> <p>Based on observation, interview, and record review, the facility failed to provide incontinence care to dependent residents.</p> <p>This applies to 2 of 5 residents (R7 and R10) reviewed for incontinence care in the sample of 10.</p> <p>The Findings include:</p> <p>1. R7 is an [AGE] year-old, with diagnoses including type 2 diabetes mellitus, osteoarthritis, bipolar disorder, anxiety disorder, dementia, stage 4 kidney disease and adult failure to thrive. R7 was admitted to the facility on [DATE].</p> <p>R7's MDS (Minimum Data Set), dated March 3, 2024 and September 3, 2024 showed R7's cognition was severely impaired. The MDS showed R7 was dependent from staff for ADL (Activities of Daily Living) including toilet needs and hygiene.</p> <p>R7's care plan, dated September 3, 2024, showed R7 was incontinent of bladder and bowel elimination and requires assistance for toilet needs and hygiene.</p> <p>On September 30,2024, at 11:00 A.M., R7 was sitting in her wheelchair in her room. V7 and V17 (CNAs/Certified Nurse Assistants) assisted R7 to the bathroom. V7 said the last time she changed R7's incontinence brief was around 9: 00 A.M. V17 and V7 did not provide care at this time, due to R7's refusal to rise from the chair. Later, at 2:30PM, V7 and V17 provided care, and R7 was noted to be heavily saturated with urine. R7's pants and clothing were noted to be saturated with urine. V7 confirmed no other attempts had been made to provide care to R7 between 11:00AM and 2:30PM.</p> <p>On September 30, 2024 at 4:30 P.M., V10 (LPN/Licensed Practical Nurse/MOD/Manager on Duty on September 21,2024 day shift) said V33 (R7's POA, Power of Attorney for Health Care) had complained on September 21, 2024 when she came in at 11:30 A.M. and saw R7 heavily saturated with urine. V10 said she saw R7's incontinence brief V33 had complained about. V10 said it appeared that the brief was saturated with urine.</p> <p>On October 01,2024 at 10:35 A.M., V11 (LPN, assigned to R7 on September 21,2024 day shift) said V33 came in around 11:30 A.M. on September 21, 2024. V11 said R33 had complained R7 was heavily saturated with urine that was soaked though all the way R7's clothes and bed sheets. V11 said she saw the brief that was heavily saturated with urine.</p> <p>2. R10, a [AGE] year-old, with diagnoses of Alzheimer's disease, dementia, type 2 diabetes mellitus, stage 4 kidney disease. R10 was admitted to the facility on [DATE].</p> <p>The MDS, dated [DATE], May 25,2024, and May 25,2023, showed R10's cognition was severely impaired. R10 also requires extensive assistance from staff for ADLs (Activities of Daily Living) including toileting and hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On October 01,2024 at 11:15 A.M., R10 was noted to be in bed. V7 and V26 (Nurse Aide/CNA) were observed providing incontinence to R10. The incontinence briefs that R10's was wearing was heavily saturated with urine, and the brief padding had already coagulated into a gel. V7 and V26 said they have not provided incontinence care to R10 since they came to work at 6:00 A.M.</p> <p>The facility policy for incontinence care, dated October 20,2021, showed:</p> <p>Policy Statement; Our facility will ensure and provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible.</p> <p>12. Incontinence Care</p> <p>a. Incontinence care will be provided by nurse or C.N.A every shift based on incontinence needs of resident. Staff will ensure that incontinence care needs are met.</p> <p>b. Staff will check, and change based on frequency of needs and will keep resident clean and dry.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15845</p> <p>Based on interview and record review, the facility failed to provide nutritional supplement to prevent weight loss to a resident who had history of significant weight loss. This applies to 1 of 3 residents (R1) reviewed for nutritional supplement in the sample of 10.</p> <p>The findings include:</p> <p>The EMR (Electronic Medical Record) showed R1 is a [AGE] year-old with diagnoses of ALS (amyotrophic lateral sclerosis), gastroenteritis, colitis, epilepsy, BPH (benign prostatic hypertrophy), and lack of coordination. R1 was admitted to the facility on [DATE].</p> <p>The MDS (Minimum Data Set), dated August 24,2024, showed R1 was cognitively intact with BIMS (Brief Interview Mental Status) score of 15/15. The MDS also showed R1 showed no negative behavior including verbal, physical threatening and had not rejected care.</p> <p>The POS (Physician Order Sheet) for the month of September 2024 showed a physician order, dated August 27, 2024, for High Calorie drink two times a day, nursing to give 237 ml-240 ml. with preferred flavor of vanilla or strawberry.</p> <p>The care plan, dated October 01,2024, showed:</p> <p>-R1 has had significant loss in weight which multi-factorial in nature, abdominal pain, and constipation with decreased intake at times; has ongoing varied intake; is a finicky eater, and decreased ability to feed self due to progression of ALS diagnosis. The goal was for R1's nutritional status to be maintained, and without significant weight loss. The intervention included nutritional supplement (High Calorie drink 2 times a day) be given as ordered.</p> <p>The Nutrition/Dietary Notes, dated September 18,2024, showed V14 (Dietitian) had changed the High Calorie drink to a different brand (clear type supplement) due to R1's intolerance to the regular supplement. The notes also showed the supplement was needed to boost calorie intake and prevent R1's weight loss.</p> <p>On October 01,2024 at 12:30 P.M., V14 said R1 had been having loose stools due to the High Calorie drink. V14 also said R1 was not able to tolerate the High Calorie drink, and it was also exacerbated by R1's diagnoses of colitis and gastroenteritis. V14 said this was the reason why the nutritional supplement was changed to the clear supplement on September 18, 2024. V14 added R1 was a high risk of acquiring significant weight loss due to ALS diagnosis, was a very picky eater, meal intake was variable, and most of all, R1 has had history of significant weight loss. V14 added the supplement was an intervention to R1 for weight loss prevention.</p> <p>A review of the EMR (Electronic Medical Record) showed R1 did not receive the supplement September 19, 20, 21, 25, and 26. V3 (Interim DON/Director of Nursing) and V14 (Nurse) confirmed this information.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On September 30,2024 at 1:15 P.M., V5 (Ancillary staff) said she was not able to order the clear supplement because she was off for 10 days. V5 said she only ordered it on September 24,2024, it arrived the 26th, and was given to R1 on the 27th of September 2024.</p> <p>On September 30,2024 at 12:36 P.M., R1 said he cannot tolerate the regular High Calorie drink, as it gives him abdominal pain and loose stools. R1 said due to this reason, it was changed to the clear supplement. R1 confirmed he was not provided the supplement until September 27, 2024.</p> <p>The facility's Weight Management Policy, dated June 20,2024, showed:</p> <p>INTENT: It is the policy of the facility to provide care and services related to weight management .</p> <p>15. RD to plan person-specific nutrition related goal(s), implement plan/interventions, and reevaluate .</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15845</p> <p>Based on interview and record review, the facility failed to follow physician orders to administer neuromuscular medication to a resident (R1) with diagnosis of ALS (amyotrophic lateral sclerosis) and a neuropathy pain medication to a resident (R2) with diagnosis of diabetic neuropathy.</p> <p>This applies to 2 of 2 residents (R1 and R2) reviewed for significant medications in the sample of 10.</p> <p>The findings include:</p> <p>1. The EMR (Electronic Medical Record) showed R1 is a [AGE] year-old, with diagnoses of ALS, gastroenteritis, colitis, epilepsy, BPH (benign prostatic hypertrophy), and lack of coordination. R1 was admitted to the facility on [DATE].</p> <p>R1's MDS (Minimum Data Set) assessment, dated August 24,2024, showed R1 was cognitively intact.</p> <p>R1's care plan, dated October 01, 2024, showed to administer R1's ALS' medication as ordered by the physician to address ALS disease process.</p> <p>The POS (Physician Order Sheet) for the month of September 2024 showed a physician order, dated August 18, 2024, for Riluzole 50 mg film tablet one tab twice a day for ALS. The order was changed on September 5, 2024 for Riluzole 50 mg tablet every 12 hours.</p> <p>Review of Medication Drug Book (2024) showed Riluzole is used for ALS and other motor neuron disease. This medication is used to delay the onset of ventilator-dependence or tracheostomy.</p> <p>On October 1, 2024 at 2:45 P.M., together with V4 (ADON/Assistant Director of Nursing), R1's EMAR (Electronic Medication Administration Record) for the month of September 2024 was reviewed. There was no documentation R1 had received Riluzole 50 mg. film tablet on September 5, 6, 7, and 8 of 2024. V4 said based on the EMAR documentation, R1 missed a total of 8 doses. V4 also said R1 had reported to her that he did not receive his Riluzole medications for many days, and therefore, V4 had reordered the medication on September 9, 2024.</p> <p>On September 30,2024 at 12:36 P.M., R1 said he did not receive his Riluzole 50 mg. film tablet for at least 5 days. R1 said he reported this to V4. R1 also said this medication was ordered by his neurologist to delay the disease process of his ALS.</p> <p>2. The EMR showed R2 is a [AGE] year old, with diagnoses of diabetic mellitus type 2, RA (rheumatoid arthritis), COPD (chronic obstructed pulmonary disease,) lack of coordination, morbid obesity and neuropathy. R2 was admitted to the facility on [DATE].</p> <p>R2's MDS, dated [DATE], showed R2's cognition was moderately impaired.</p> <p>R2's care plan, dated August 12,2024, showed R2 was on pain management related to neuropathy and RA. Intervention included administration of pain medications as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The POS for the month of September 2024 showed an order for Gabapentin 100 mg. twice a day for neuropathy pain scheduled to be given 9:00 A.M. and 5:00 P.M.</p> <p>On September 30,2024 at 12:34 P.M., R2 said he was not administered his scheduled 9:00 A.M. morning medications, and was still waiting from V28 (Registered Nurse). V28 reviewed the EMAR and it showed all R2's scheduled 9:00 A.M. medications were not yet administered.</p> <p>On October 01,2024, at 4:30 P.M., V13 (Nurse Practitioner) said R1's Riluzole medication was to for R1's ALS and is a significant medication, and by not administering this medication, it was a significant medication error. V13 said R2's Gabapentin 100 mg. medication twice a day that was scheduled at 9:00 A.M. and 5:00 P. M. was a significant error, since this pain medication for neuropathy should be space equally for administration, to maximize the optimum effect of pain control.</p> <p>The facility's policy for Medication Pass, dated March 20,2024, showed: INTENT: All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis.</p>