STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145234	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl Pavilion	900 South Kiwanis Drive Freeport, IL 61032

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 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 33761 Based on observation, interview and record review the facility failed to provide assistance with ADL's (Activities of Daily Living). This failure resulted in R1 being left on the bed pan unattended leading to feelings of pain, frustration, panic and embarrassment. This applies to 1 of 3 residents reviewed for assistance with ADL's in a sample of 6 residents. The findings include: R1 Face sheet shows his diagnoses to include acute respiratory failure with double lung transplant, protein-calorie malnutrition, pneumonia, and type 2 diabetes mellitus. R1's 3/18/24 MDS (Minimum Data Set) shows, he is fully cognitively intact, and needs substantial/maximal assistance rolling left and right. R1's 3/12/24 POS (Physician Order Sheets) shows Physical and Occupational therapy is to evaluate and treat as indicated 3-5 times a week. R1's 3/13/24 Care Plan shows he has a self care deficit and is dependent with ADL care. The facility must provide total assistance in all aspects of hygiene/dressing. R1's 3/21/24 Progress Note, by V10 (Nurse Practitioner) shows R1 was referred to skilled therapy related to a noted functional decline. R1 has a decrease in strength, balance, transfers, mobility, and the ability to perform self-care ADL's. The same progress note shows R1 is alert and oriented to person, place, and time. On 4/2/24 at 10:00 AM, R1 said, on 3/29/24 at 11:00 AM he was placed on the bed pan, and when he was finished having a bowel movement pressed his call light to be taken off. R1 said, staff kept coming in and shutting off the call light and telling him (R1) they would be right back and never returned. R1 said, the bed pan was starting to hurt his bottom and he was feeling frustrated, R1 said, it was like he didn't matter. R1 said, he finally called 911 because he couldn't take it anymore and was starting to panic. R1 became emotional and started to weep when relaying this event. R1 said, it's embarrassing to have to use a bed pan but to be on it for 3 hours and then have a room full of EMS and staff to take him off caused more embarrassment. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145234	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl Pavilion	900 South Kiwanis Drive Freeport, IL 61032

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 0677 Level of Harm - Actual harm Residents Affected - Few	On 4/2/24 at 1:00 PM, V7 CNA said, she was R1's CNA on 3/29/24, the day R1 called 911. V7 said, her normal shift is 10:00 AM to 10:00 PM but she was late that day. V7 said, she put R1 on the bed pan, but she couldn't remember what time. V7 said, it was before lunch because she remembers R1 was still on the bed pan when she delivered his lunch tray. V7 said, she didn't take him off the bed pan because she got busy and thought someone else would do it. V7 said, she doesn't know what time he (R1) was taken off the bed pan. On 4/2/24 at 9:45 AM, V2 DON (Director of Nursing) said, we have video of staff going in R1's room several times, so V2 thinks R1 was put on the bed pan at 1:00 PM and taken off at 2:40 PM. V2 said, she assessed R1's bottom at 2:40 PM when EMS (Emergency Medical Service) arrived. V2 said the staff should answer the call light as soon as possible because the resident may be in distress. On 4/2/24 at 1:00 PM, V4 CNA said, R1 is alert and oriented. V4 said, staying on the bed pan for longer than 1/2 an hour is too long. V4 said the resident should come off the bed pan and try again later, because staying on the bed pan too long could cause skin break down. On 4/2/24 at 1:00 PM, V5 CNA said, R1 is alert and oriented. V5 said, staying on the bed pan for longer than 1/2 an hour is too long. V5 said, the resident should come off the bed pan and try again later, because staying on the bed pan too long could cause skin break down. On 4/2/24 at 10:15 AM, V3 (Wound Nurse) said, a 1/2 hour to 1 hour on the bed pan is too long because it might cause skin breakdown. The CNA should take the resident off the bed pan and the resident should try later to use the bed pan. A Policy and Procedure for Bed Pan use and for assistance with ADL's was requested, however V1 (Administrator) said, they did not have one.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145234	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl Pavilion	900 South Kiwanis Drive Freeport, IL 61032

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33761 Based on observation, interview, and record review, the facility failed to ensure a care plan and interventions were developed and implemented to prevent pressure ulcers, failed to provide pressure ulcer treatment, and failed to update interventions to the care plan and update the skin risk assessment once pressure ulcers developed for 2 of 3 residents (R1, R3) reviewed for pressure ulcers on the sample list of 6. The findings include: 1. R1's Face Sheet shows his diagnoses to include acute respiratory failure with double lung transplant, protein-calorie malnutrition, pneumonia, and type 2 diabetes mellitus. On 4/2/24 at 10:00 AM, R1 was in his bed with the bed pan under his bottom. When R1 was finished he was rolled by the CNA (Certified Nursing Assistant) and there was no dressing on his pressure wound on his buttocks. The old dressing was not on the pad beneath R1 or in the bed pan. On 4/2/24 at 1:00 PM, V4 and V5 both CNAs said, R1 is alert and oriented. V4 and V5 said, if a dressing falls off or gets soiled, the CNA should tell the floor nurse so the dressing can be replaced. On 4/2/24 at 10:15 AM, V3 (Wound Nurse) said, if the CNA sees that the dressing has come off they should let the nurse know so the dressing can be replaced. V3 said, having a wound exposed to stool can be an infection risk. R1's 4/1/24 (12:34 PM) Progress Notes shows a stage 2 pressure wound on his bilateral buttocks, and an order for by V8 (wound Physician) for a hydrocolloid thin dressing for both the right and left buttocks. R1's POS (Physician Order Sheet) shows, to apply a hydrocolloid thin dressing for both the right and left buttocks on Monday-Wednesday-Friday and as needed. 40798 2. R3's Admission Record dated 4/2/24 shows she was admitted to the facility on [DATE]. R3's Admission/Readmission Screener dated 11/21/23 shows R3 had no skin abnormalities (i.e. bruising, skin tears, pressure injuries, etc). R3's current care plan (initiated on 11/21/23) shows R3 is at increased risk for alteration in skin integrity, R3 will not develop any skin integrity issues and the only intervention is to check R3's skin during routine care and during her weekly bath/shower; no prevention interventions were implemented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145234	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl Pavilion	900 South Kiwanis Drive Freeport, IL 61032

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's Skin/Wound Note dated 4/1/24 at 12:28 PM shows R3 has a new Stage 2 wound to her left buttock. R3's Wound Evaluation & Management Summary dated 4/1/24 shows R3 has a Stage 2 Pressure Wound of the left, medial buttock. The wound physician, V8, recommendations include the following: limit sitting to 60 minutes, turn side to side in bed every one to two hours, and off-load the wound. R3's care plan does not reflect those recommendations and includes no additional interventions once the Stage 2 pressure ulcer was identified. The most recent pressure injury risk assessment tool the facility provided was completed on 3/12/24. On 4/2/24 at 12:01 PM, V2, Director of Nursing (DON), said the interdisciplinary team (IDT) communicates daily and discusses any new wounds and determines what interventions need to be added and implemented. If a pressure ulcer is found the pressure injury risk assessment is updated. The care plan is updated so interventions are in place to minimize impairment to skin integrity. V2 said, There is no prevention for anything, only God can prevent things from happening; I don't like the word prevent. V2 said they put interventions in place to minimize risk. The facility's Wound Policy (Revised 11/2022) shows a pressure injury risk assessment should be completed when a significant change of condition occurs. The goals of wound treatment are to: keep the ulcer bed moist and the surrounding skin dry, protect the ulcer from contamination, and promote healing.