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	05/07/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22499 Based on observation, interview, and record review the facility failed to assess and document a resident's non-pressure (venous) wounds. The facility also failed to follow up with the resident's physician after a visit at his office and failed to follow physician orders written during that visit. This failure resulted in R1 having no wound assessments since January 2024 for 4 venous wounds on her legs, R1 having exposed open and bleeding wounds to the backs of her thighs, and R1experiencing an 18 day delay in increasing her pain medication. This applies to 1 of 3 residents (R1) reviewed for quality of care in the sample of 7. The findings include: R1's EMR (Electronic Medical Record) shows that R1 was admitted to the facility on [DATE] with diagnoses including Morbid Obesity, Mood Disorder, Chronic Kidney Disease, Stage 4 and non-pressure chronic ulcers of the left and right leg. R1's last wound assessment is dated 1/15/2024 on a document entitled Specialty Physician Wound Evaluation and Management Summary shows that R1 has 4 venous wound. Wound 1 is on her left posterior , medial leg and measures 21.2 x 25.0 x 0.1 centimeters (cm.) This wound has a moderate amount of serous drainage. Wound 2 is on the right medial calf and measures 8.5 x 8.5 x 0.1 cm with a moderate amount of serous drainage. Wound 3 is on the right posterior thigh and measures 12.5 x 17.5 x 0.2 cm and has a heavy amount of serous drainage. Wound 4 is on the left medial thigh and measures 6.5 x 6.5 x 0.1 cm and has heavy serous drainage. This document shows that she is allergic to silver. The facility undated (current?) Non- Pressure Injury list shows that R1 has 2 venous wounds. The left posterior medial lower leg and the right medial calf. The treatment for both of these wounds is listed as Calcium Alginate with Silver. This form also lists the wrong physician for R1. R1's Treatment Administration Record for April and May 2024 shows that R1 has an order dated 1/30/24 for Calcium Alginate Silver to both lower extremities every night shift. (Four areas Right calf, right posterior thigh, left posterior leg and left medial thigh). These documents show that R1 allowed the dressing to be changed 10 times in 37 days. (10 times in which an assessment could have been completed) (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/24 at 11:15AM, R1 was seated in her wheelchair in her room. R1 had a bed pad on the floor under her chair and another one across from her chair under her bedside commode. R1's legs were wrapped with ace wraps and appeared to have gauze or ABD pads underneath them. R1's legs were positioned only on the foot pedals of the wheelchair as she stated the leg rests hurt her legs. The foot pedals were wrapped in white sheet like fabric that was stained with yellow drainage. R1 was dressed in a gown and had about 3 blankets covering her lap. When R1 moved in the chair she emitted a very strong ammonia odor. R1 stated, I have had 2 bacterial infections in my legs. I worked here in housekeeping and laundry and there is suspicion that I picked up the bacteria here. I had an allergy to all the cleaning products and I got a rash all over my arms and legs. Then I got the open wounds on my legs and I was covering them with gauze pads and ace wraps. There was so much drainage that I was changing the dressings 8-10 times a day. I was losing fluid like a faucet. I was going to the wound care clinic and they would scrape off the slough and use lidocaine to numb the area. I am allergic to lidocaine to but I can use it on my legs like that. They would cover with an ABD, Kerlix and ace bandages. I stopped going to the wound clinic by my own choice after going there for 6-8 months and the legs were not getting better. My primary physician put me down that I can do my own wound care. The facility physician, I saw him once- I won't see him again. I don't like the Calcium Alginate they ordered- they used that at the clinic and it did not work. They use it here with the silver and I am allergic to silver. The nurses only change my dressing at night. If I am sleeping they do not do it- then I do it myself. They are supposed to help me change it when it is saturated but they will only do it at night. I made my own bandages from their blankets. I cut them in strips. I only elevate my legs as much as the chair will allow. I haven't laid in a bed in [AGE] years. I put the cornstarch on to soak up the fluid and it keeps them dry. The doctor is going to change the order to include that I can put the cornstarch on the wounds- he just got back to me today after calling for a week. I got the cornstarch back a couple days ago. I was out. They have to get it for me since I don't have an order for it- until today. I wash my legs with distilled water. I can't store the wound cleanser in my room so I have to use the water. Some nurses will put the cornstarch on. Cornstarch is the only thing that has worked so far. I just leave the old crusty skin until it falls off. I use cornstarch on my bottom too. R1 then insisted on standing up with walker to show Surveyor her backside. It took R1 some effort but she was able to stand independently with walker then turned so Surveyor could see the backs of her thighs. The backs of both of R1's thighs had large amounts of very red skin, patchy yellow crusty skin and open, bleeding areas. When R1 stood up the odor was overpowering. The sheet that R1 was sitting on was wet with yellow fluid and blood stains. R1 touched several areas with her fingers trying to show Surveyor the open areas. R1 folded the sheet she had been sitting on to show a clean area, poured about 1 cup of cornstarch on the sheet and sat back down in the chair. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/24 at 1:40 PM V4 (RN) stated, The last time I changed her dressing she refused to have the Calcium Alginate applied. She told me if I tried to put that on her again that she would not let me back in her room. I tried to educate her but she wants it done her way. She wants us to clean her legs with distilled water and then the Vashe (wound cleanser) and then apply the corn starch. She says the way she does it is the best way. I tried to tell her I can't put the corn starch on there but then she starts using profanity. I work overnights and leave at 6:30 AM. She asked me to tell the wound nurse that she just went to the doctor and he changed the order and she said she is going to her primary MD soon. Her wounds on her legs close up a little bit and they are very dry and excoriated and red. They are trying to heal. Her ankles have this thick skin on them and the only thing that comes off when you clean her legs is the old corn starch. She scratches all the time. She says she doesn't but I see her picking the skin off. The last time I did her dressings it took me 2 hours and 40 minutes. She won't get into a bed, won't elevate her legs. I clean her legs and she puts the cornstarch on them. I will not do it. We do not have an order for that. I have reported to the ADON, the wound MD will not see her anymore. She limits who she will allow to do her treatments so sometimes they do not get done or she does them herself. They do not look infected but they keep opening because they are constantly moist. On 5/6/24 at 2:30 PM V7 (LPN- Wound Nurse) stated, As I understand it she worked here and had issues back then with hygiene and her legs. She doesn't want to see any doctors associated with this facility. She won't see our medical director, won't have labs done here and won't see the wound care MD. Her legs were pretty good for a while but then she insists on using corn starch on them. She doesn't want to have to pay for anything, she uses her call light when she needs something, refuses to shower. She swears she is allergic to soap and water. About 1 week ago I saw her legs. I was not aware that there were any open areas on the backs of her legs. Most of the dressings she does herself. Sometimes she refuses to allow staff to change her dressings. I don't know the last time she saw a doctor. She never gives us the paperwork. She takes the bus to all her appointments, will not go in an ambulance. The last wound assessment I did was around April 22- there are no measurements. I just did the fronts of her legs and she didn't want me to go any higher than her knee. I wrote it on my notes as I was working but didn't put it in (EMR) yet. V7 later showed Surveyor a hand written note that stated R1's legs were worse and drippy but there was no further assessment. On 5/6/24 at 3:00PM V2 (Director of Nursing) stated, She saw our house physician one time and then she started going out to (V10- NP). She doesn't come back with any papers and we can try to reach out for progress notes but then we don't get the fax. There is nothing I can do about that. I can follow up with them but I don't know exactly the last time she went. I won't apply the cornstarch for her. She will stand up only for the CNAs to help her to the commode. I did the dressings about 4 nights ago. She let me do everything except apply the Calcium Alginate. Surveyor asked V2 for her wound assessment and communication with R1's Physician- pointing out that there is an order for Calcium Alginate with Silver and R1 has an allergy to silver. V2 replied, We do the weekly assessments. V7 stated, I am behind on those. V2 stated (angrily) Well how was I supposed to know she needed an assessment? On 5/7/24 the facility presented a progress note written by V10 showing that he saw R1 on 4/19/24. During this visit V10 wrote an order to increase R1's Gabapentin (Nerve pain medication) from 600mg three times a day to 800 mg three times a day. This order was added to R1's medical record on 5/7/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/24 at 11:10 AM V8 (Social Service Director) stated, (R1) does her own thing and doesn't really keep us in the loop. She makes her own appointments and doesn't bring back any of the paperwork. On 5/7/24 at 4:00 PM, V11 (Medical Director) stated that he was familiar with R1's name but the faciltiy had not discussed R1's wounds and refusals of treatment and care with him. The facility policy entitled Pressure Ulcer and Skin Condition Assessment Policy dated 1/1/24 states, Non-Pressure will be assessed every 7 days and recorded in the medical record. The facility policy entitled Physician Orders dated January 2024 states, Physician's orders must be documented clearly in the medical record and/ or (EMR).