

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/01/2024
NAME OF PROVIDER OR SUPPLIER  Pearl Pavilion		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20042</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure a shower or bath and/or hair care were provided for 3 of 3 residents (R1, R2, &amp; R6) reviewed for activities of daily living in a sample of 6.</p> <p>The findings include:</p> <p>1. The hospital emergency room Nurse's Note dated 9/18/24 for R1 showed, Patient arrived from facility with poor hygiene care. Patients hair was matted with food in it. Indwelling urinary catheter bag clogged with large sediment, exterior catheter visibly dirty. Patient had a pungent smell. The nurse bed bathed patient, applied shower cap, changed indwelling urinary catheter. This nurse made provider aware of patient status.</p> <p>On 9/26/24 R1 could not be observed at the facility; R1 was still in the hospital.</p> <p>On 9/26/24 at 11:42 AM, V6 CNA (Certified Nursing Assistant) stated, residents' showers are on a schedule and are done at least once a week. If a resident refuses a shower they are supposed to ask the resident three times and then get the nurse who will ask the resident. V6 stated the shower sheet is then left for the next shift and they will try to do the shower. V6 stated nail care and shaving is also completed on shower days; it is on the shower sheet and the resident's care plan. V6 stated showers are getting done like they should be.</p> <p>On 9/26/24 at 3:43 PM, V2 DON (Director of Nursing) stated, everyone should have a shower or bath weekly and as needed. V2 stated if the resident refuses she tells staff to fill out a shower sheet and the nurse has to sign it. V2 stated the nurse should document in the progress notes about it and then the form is filed. V2 stated she tells staff to re-approach the resident for a total of three times. Staff should find out if the resident is not interested in a shower just for that day and/or time and then let her know so she can re-arrange the shower schedule. If a resident continues to refuse showers/baths then it needs to be brought up to the administrator or corporate nurse to get something in place. V2 stated nothing has been brought up for R1. V2 stated she doesn't look at the shower tracking.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The August 2024 Shower Tracking Master form showed R1 did not have a shower for 13 days between 8/1/24 until 8/14/24. The Shower Sheets for R1 showed on 8/14/24 a family member gave R1 a bed bath. The August 2024 Shower Tracking Master form showed R1 had a shower/bed bath on 8/21/24. The Shower Sheet dated 8/21/24 for R1 showed she refused a shower on that date. There weren't anymore shower sheets for R1 for August. R1 went without a shower or bed bath for 16 days from 8/15/24 - 8/31/24.</p> <p>There were two Shower Sheets for R1 for the month of September 2024 up until her admission to the hospital on 9/18/24. R1's shower sheet dated 9/5/24 said to see treatment notes and did not document that she had a shower or bed bath that day on the sheet or in the treatment notes. The Shower Sheet for R1 dated 9/17/24 showed a refusal of a shower times 3 that day. The last documented shower/bed bath for R1 was on 8/14/24; 34 days prior to her admission to the hospital.</p> <p>The Care Plan dated 7/22/24 for R1 showed, resident has a self care deficit Bed baths only related to chronic wounds. Resident is dependent with activity of daily living care; provide total assistance in all aspects of hygiene/dressing.</p> <p>The Shower/Bathing Policy (4/2021) showed, showers/bed bath will be offered at least once per week, per resident preference and time.</p> <p>2. On Thursday, 9/26/24 at 11:09 AM, R2 was laying on his bed in his room wearing an incontinence brief. R2 has an amputation of his right lower leg. R2 had greasy hair and had a mustache and beard starting to grow on his face. R2 stated he doesn't get showers once a week. R2 stated he is able to stand on his one leg in the shower to get cleaned up but staff don't take the time. R2 stated his hair is oily and his skin is rough. R2 stated he has a mustache and beard growing but prefers to be clean shaven but cannot do it himself. R2 stated they are supposed to get showers once a week but don't. R2 stated he sweats in his groin area and it stinks; he feels dirty. R2 denied refusing showers.</p> <p>On 9/26/24 at 11:42 AM, V6 CNA (Certified Nursing Assistant) stated, residents' showers are on a schedule and are done at least once a week. If a resident refuses a shower they are supposed to ask the resident three times and then get the nurse who will ask the resident. V6 stated the shower sheet is then left for the next shift and they will try to do the shower. V6 stated nail care and shaving is also completed on shower days; it is on the shower sheet and the resident's care plan. V6 stated showers are getting done like they should be.</p> <p>The Face Sheet dated 9/26/24 for R2 showed diagnoses including congestive heart failure, type 2 diabetes mellitus, paroxysmal atrial fibrillation, acute pulmonary edema, pleural effusion, acute respiratory failure, peripheral vascular disease, hypertensive heart disease, cardiomyopathy, permanent atrial fibrillation, morbid obesity, atherosclerotic heart disease, anemia, hyperlipidemia, hyperkalemia, major depressive disorder, generalized edema, insomnia, and acquired absence of right leg above knee.</p> <p>The second floor's Shower Schedule (no date) was reviewed and showed R2 is to have a shower on Thursday mornings.</p> <p>The Shower Sheets for R2 were reviewed and showed no shower sheet for him between 8/8/24 and 8/22/24 (14 days between showers). The Shower Sheets for R2 for September 2024 showed his last shower was 9/6/24; as of 9/26/24 at 11:09 AM R2 had not had a shower for 20 days.</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>The MDS (Minimum Data Sheet) dated 6/24/24 for R2 showed no cognitive impairment; substantial/maximal assistance for personal hygiene.</p> <p>The Care Plan dated 7/3/24 for R2 showed, resident has a self care deficit - activities of daily living/mobility. Encourage resident to participate as much as safely able with activities of daily living hygiene tasks. The care plan did not show how much assistance needed with showers and the frequency of showers.</p> <p>The Shower/Bathing Policy (4/2021) showed, showers/bed bath will be offered at least once per week, per resident preference and time.</p> <p>3. On 9/26/27 at 11:18 AM, R6 was sitting up in his bariatric bed wearing a hospital type gown. R6's hair looked greasy and was sticking up. R6 stated he receives a bed bath once every couple of weeks and it bothers him. R6 stated when they do clean him up with a bed bath he has the staff soak a towel with water and soap on it so he can wash his hair off. R6 stated he doesn't know when the last time his hair was actually washed.</p> <p>On 9/26/24 at 11:28 AM, V4 CNA (Certified Nursing Assistant) stated the resident's have scheduled days for showers/bed baths. If a resident refuses it is written on the shower sheet as well as if they couldn't get to the shower/bath. V4 stated the shower sheets get turned into a basket, the wound nurse looks at them. V4 stated when a shower is done they clean all of the resident and wash the resident's hair. If the resident has a bed bath then their hair is washed with a basin, water, and towel. V4 stated shaving is done if needed or if the resident asks for it to be done.</p> <p>The second floor's Shower Schedule (no date) was reviewed and showed R6 is to have a bed bath on Friday mornings. The August 2024 Shower Tracking Master form showed R6 had two bed baths for the month on 8/6/24 and 8/26/24. The Shower Sheets for R6 showed on 9/6/24 he received a partial bed bath; hairwashing was not documented as being completed. On 9/16/24 R6 had a bed bath; the shower sheet did not show documentation of his hair being washed. On 9/23/24 R6 had a partial bed bath; the shower sheet did not show documentation of his hair being washed.</p> <p>The MDS dated [DATE] for R6 showed he is cognitively intact; dependence for shower/bathing, personal hygiene, dressing, and toileting hygiene.</p> <p>R6's Care Plan dated 9/20/24 showed, resident has a self care deficit. Resident is dependent on activity of daily living care; provide total assistance in all aspects of hygiene/dressing.</p> <p>The Face Sheet dated 9/26/24 for R6 showed diagnoses including hypertension, peripheral venous insufficiency, lymphedema, atrial fibrillation, morbid obesity, neuromuscular dysfunction of the bladder, and sleep apnea.</p> <p>The Shower/Bathing Policy (4/2021) showed, showers/bed bath will be offered at least once per week, per resident preference and time.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>20042</p> <p>Based on observation, interview, and record review the facility failed to ensure a residents wound dressings were being changed for 1 of 3 residents (R3) reviewed for wounds in the sample of 6.</p> <p>The findings include:</p> <p>On 9/26/24 at 10:48 AM, R3 was in therapy and had gauze wrapped around his right elbow that was secured with tape. The dressing was not dated. V5 (R3's daughter) was present and stated, R3 came here last Tuesday (9/17/24) evening; he was in the hospital. R3 has a wound to his elbow and swelling. The wound drains and has packing in it. One day it was draining and I had to keep asking them to change it (dressing) and they never did. V8 (R3's son) asked them three times that day and they did not change it. When I came the next day the dressing had dirty, crusty drainage.</p> <p>On 9/26/24 at 3:24 PM, V7 LPN (Licensed Practical Nurse/Wound Nurse) stated, R3 had silver rope ordered as a packing for the right elbow when he was admitted to the facility and they were waiting for it to come in because they did not have it. They got an order from the facility's medical director to do the iodoform packing. V7 stated dressing changes are documented on the TAR (Treatment Administration Record). V7 stated R3's dressings are now being done daily. V7 stated on 9/23/24 R3's family was asking for his dressing to be changed. V7 stated she changed R3's dressing on 9/23/24.</p> <p>On 9/26/24 at 3:43 PM, V2 DON (Director of Nursing) stated she thought it was Monday (9/23/24) that R3's family stated his dressing was never changed. V2 stated when she came in on Tuesday (9/24/24), V5 (R3's daughter) came to her and told her R3's dressing was not changed on Monday. V2 stated by the time she went to see R3 on 9/24/24 his dressing had been changed. V2 stated she did not talk to V7 about R3's dressing change; she assumed V7 forgot it.</p> <p>The Physician Order Summary Report dated 9/26/24 for R3 showed the following orders: on 9/18/24 - xeroform petroleum gauze, apply to left elbow topically every day shift on every Monday, Wednesday, and Friday. Cleanse area with wound cleanser, pack with iodoform packing, apply xeroform, cover with kerlix and elastic wrap, and elevate. On 9/20/24 the order changed, xeroform petroleum gauze, apply to left elbow topically every day shift on every Monday, Wednesday, and Friday. Cleanse area with wound cleanser, pack with iodoform packing, apply xeroform, cover with kerlix and self adhesive bandage, and elevate. On 9/24/24/24 the order changed to packing strips - apply 36 inch transdermally every day shift for wound care. Cleanse with wound cleanser, pat dry, pack with 1/4 inch packing strips to right elbow (approximately 3 feet) and cover with 4 x 4 border gauze.</p> <p>The TAR (Treatment Administration Record) dated September 2024 for R3 showed, xeroform petroleum gauze, apply to left elbow topically every day shift every Monday, Wednesday, and Friday. Cleanse area with wound cleanser, pack with iodoform, cover with kerlix and self adhesive bandage and elevate. R3's TAR showed this treatment was not documented as being completed on 9/23/24.</p> <p>The Care Plan dated 9/17/24 for R3 did not show a focus area with interventions related to the wound on his right elbow.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Face Sheet dated 9/26/24 for R3 showed diagnoses including cellulitis of right upper limb, olecranon bursitis of the right elbow, hypertension, atrial fibrillation, and spinal stenosis.</p> <p>The hospital Discharge Summary dated 9/17/24 for R3 showed he had went to the hospital with increased redness and swelling of his right elbow that was indicative of celulitis and abscess formation the olecranon bursa. R3 had an orthopedic consultation and an incision and drainage done of the olecranon bursa. Staphylococcus aureus was cultured which was sensitive to methicillin. Physical therapy and occupational therapy were utilized and they indicated that he was an excellent candidate for ongoing therapy and dressing changes at the nursing home.</p> <p>The facility's Pressure Ulcer and Skin Condition Assessment Policy (1/1/24) showed, non-pressure will be assessed every 7 days and recorded in the medical record. Purpose: To establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, reassure and other ulcers and assuring interventions are implemented. Dressings which are applied to pressure ulcers, skin tears, wounds, lesions or incisions shall be checked daily for placement, cleanliness, and signs and symptoms of infection. Physician ordered treatments shall be initialed by the staff on the Treatment Administration Record after each administration. Other nursing measures not involving medications shall be documented in the progress notes.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>20042</p> <p>Based on observation, interview, and record review the facility failed to ensure residents with pressure ulcers had pressure reducing/preventative measures in place for 2 of 3 residents (R2 and R3) reviewed for pressure injuries in the sample of 6.</p> <p>The findings include:</p> <p>1. On Thursday, 9/26/24 at 11:09 AM, R2 was laying on his bed in his room wearing an incontinence brief. R2 has an amputation of his right lower leg. R2's left heel was lying directly on his bed and not offloaded. R2 had one pillow in his bed behind his head and none at his foot level. R2 did not have an off-loading boot visible in his room.</p> <p>On 9/26/24 at 11:42 AM, V6 CNA (Certified Nursing Assistant) stated, R2 did not have any pressure ulcers; she did not notice anything the other night when providing care. At 11:52 PM, V6 went to R2's room with the surveyor and R2's left heel was laying on the bed. V6 lifted R2's left heel and there was a small black area the size of a pencil eraser on his heel with some redness around it. V6 looked in R2's room for an off-loading boot and said she could not find one. R2 stated he used to have a boot for his left foot but he didn't know where it went.</p> <p>On 9/26/24 at 3:24 PM, V7 LPN (Licensed Practical Nurse) stated R2 has a pressure ulcer to his left heel, gets skin prep to the heel and see's the wound doctor. V7 stated part of the wound care physician's order is to offload R3's left heel. V7 stated R2 would move his heel off a pillow because he can move that leg. V7 stated R2 did not have an offloading boot.</p> <p>The Face Sheet dated 9/26/24 for R2 showed diagnoses including congestive heart failure, type 2 diabetes mellitus, paroxysmal atrial fibrillation, acute pulmonary edema, pleural effusion, acute respiratory failure, peripheral vascular disease, hypertensive heart disease, cardiomyopathy, permanent atrial fibrillation, morbid obesity, atherosclerotic heart disease, anemia, hyperlipidemia, hyperkalemia, major depressive disorder, generalized edema, insomnia, and acquired absence of right leg above knee.</p> <p>The Wound Care Physician's Note dated 9/16/24 for R2 showed, stage 2 pressure wound of the left posterior heel, partial thickness with a scab. Float heels in bed; off-load wound; reposition per facility protocol; turn side to side in bed every 1-2 hours if able.</p> <p>The Care Plan dated 7/3/24 for R2 showed, resident has a self care deficit - activities of daily living/mobility. One assist with turning and repositioning. The resident is at increased risk for alteration in skin integrity. Encourage R2 to limit sitting to 60 minutes, off load wound, reposition, turn side to side if able. No shoes.</p> <p>The facility's Pressure Ulcer Prevention policy (4/2024) showed, use positioning devices to relieve the pressure from heels, toes, knees, hips, ankles, etc.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. On 9/27/24 at 12:55 PM, R3 was sitting in a chair in his room with grip socks on and his heels resting on the floor. At 2:04 PM, R3 was on his back in bed with his heels resting on the mattress. R3 did not have any offloading devices in place. At 2:09 PM, V1 (Administrator/Licensed Practical Nurse) was taken to R3's room to observe the resident. V1 stated R3's heels were not offloaded in bed. V1 asked R3 if it would be okay if he put a pillow under his legs to off load his heels and R3 said, Sure you can. V1 lifted R3's right heel up that had a small purple area to the lateral part of the heel.</p> <p>The Care Plan dated 9/17/24 for R3 did not show a focus area with interventions related to a pressure injury to his left heel.</p> <p>The facility's Pressure Ulcer List showed R3 was admitted to the facility with a deep tissue injury to his right heel.</p> <p>The Physician Order Summary Report dated 9/26/24 for R3 showed an order dated 9/20/24 for skin prep wipes topically every day shift every Monday, Wednesday, and Friday for skin care. Cleanse area with wound cleanser, pat dry, apply skin prep, offload while in bed.</p> <p>The Face Sheet dated 9/26/24 for R3 showed diagnoses including cellulitis of right upper limb, olecranon bursitis of the right elbow, hypertension, atrial fibrillation, and spinal stenosis.</p> <p>The facility's Pressure Ulcer Prevention policy (4/2024) showed, use positioning devices to relieve the pressure from heels, toes, knees, hips, ankles, etc.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>20042</p> <p>Based on observation, interview, and record review the facility failed to ensure catheter care was being provided, the drainage bag was kept off the floor, the drainage bag was maintained below the level of the bladder, and catheters were changed as needed for 2 of 3 residents (R1 &amp; R5) reviewed for catheters in the sample of 6.</p> <p>The findings include:</p> <p>1. On 9/26/24 at 11:38 AM, R5 was sitting up in bed with his catheter tubing and drainage bag visible. R5's catheter tubing had sediment in it. R5's drainage bag was covered on the sides but not the bottom and was attached to a small garbage can with the bottom of the bag on the floor.</p> <p>On 9/26/24 at 11:42 AM, V6 CNA (Certified Nursing Assistant) stated R5 has a catheter and does his own catheter care including emptying the drainage bag. V6 stated when catheter care is done it should be done every shift and included cleaning around the tubing, cleaning the tubing and emptying the drainage bag.</p> <p>On 9/27/24 at 8:27 AM, V2 DON (Director of Nursing) went to R5's room with the surveyor to observe his catheter. R5 was sitting up in bed wearing a black T-shirt and blue athletic pants. R5's shirt was raised up and his suprapubic catheter was exposed. The dressing around the catheter was a gauze dressing that was coming off; there wasn't any tape on the dressing to keep it in place. V2 removed the dressing from around the catheter tubing and said the site needed to be cleaned. The catheter tubing itself had a brownish substance encrusted around the tubing that V2 stated needed to be cleaned off. The drainage bag was partially out of the dignity bag cover and the drainage bag itself was laying on the resident's floor. V2 stated the catheter bag should not be on the floor for infection reasons. The hook at the top of the bag was partially broken. R5 had a lot of sediment in his catheter tubing. V2 picked R5's catheter drainage bag up and held it up in the air well above the level of the resident's bladder and stated the urine was yellow but cloudy. V2 stated the drainage bag is to be kept below the level of the resident's bladder to prevent back flow of urine. R5 stated staff have not done catheter care for him in a long time. R5 stated he doesn't do the catheter care himself. R5 stated it would be okay for the staff to provide catheter care. R5 stated staff do not empty his drainage bag so he has to do it.</p> <p>The Care Plan dated 9/10/24 for R5 showed, risk for infection or complications related to suprapubic catheter use; diagnosis obstructive uropathy. Observe for signs and symptoms of infection. Render catheter care every shift (notify nurse of any skin issues). Monitor indwelling catheter and change bag as needed. Monitor urine for increase sediment, cloudy urine, odor, blood &amp; output - alert nurse with concerns: call medical doctor with concern. Good peri care - being careful not to pull tubing. Monitor position of drainage bag and keep below waist to ensure proper drainage.</p> <p>The Face Sheet dated 9/27/24 for R5 showed diagnoses including type 2 diabetes mellitus, moderate protein-calorie malnutrition, iron deficiency anemia, inflammatory disorders of scrotum, obstructive and reflux uropathy, and presence of urogenital implants.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Physician Order Summary Report dated 9/27/24 for R5 showed, apply gauze and tape to skin at suprapubic catheter. Catheter care every shift during routine care every shift for catheter care. Catheter type: suprapubic; 16 F (French), 10 ml (milliliter) balloon, diagnosis - obstructive uropathy. Change catheter dressing every day, use drain sponge dressing every night shift for maintenance.</p> <p>The MDS (Minimumm Data Set) dated 8/9/24 for R5 showed no cognitive impairment; no physical, verbal, or other behaviors.</p> <p>The Treatment Administration Record dated 9/1/24 for R5 showed, catheter care every shift during routine care every shift for catheter care. The TAR showed on 9/14/24, 9/24/24, &amp; 9/25/24 showed no catheter care was marked as being completed. The Tar showed change catheter dressing every day, use drain sponge dressing and was not marked as being completed on 9/14/24, 9/24/24, &amp; 9/25/24.</p> <p>The facility's Catheter Care Policy &amp; Procedure (11/2023) showed, catheters shall be positioned to maintain downhill flow of urine to prevent back flow of urine into the bladder or tubing, during transfer, ambulation, and body positioning. Urinary drainage bags and tubing shall be positioned to prevent from touching the floor. Urinary catheter and tubing will be removed and reinserted when any of the following are observed: a. Inability to observe urine contents in the urinary drainage bag or tubing; b. Observation of gross contamination; c. Obstruction of the catheter or tubing; c. Leakage of malfunction; e. Upon physician's orders. Each resident with an indwelling catheter will receive perineal and catheter care with soap and water during routine care. Encrustations on the indwelling urinary catheter should be removed from the meatus outward with clean wash cloth, rinsed. The date of the catheter insertion shall be documented in the nurses' notes.</p> <p>2. The hospital emergency room Nurse's Note dated 9/18/24 for R1 showed, Patient arrived from facility with poor hygiene care. Patients hair was matted with food in it. Indwelling urinary catheter bag clogged with large sediment, exterior catheter visibly dirty. Patient had a pungent smell. The nurse bed bathed patient, applied shower cap, changed indwelling urinary catheter. This nurse made provider aware of patient status.</p> <p>On 9/26/24 R1 could not be observed at the facility; R1 was still in the hospital.</p> <p>On 9/27/24 at 7:55 AM, V2 DON stated R1 had an order for her catheter to be changed for obstruction, blockage, and/or malfunction before she went to the hospital. V2 stated R1 has a catheter because of he pressure ulcers. V2 stated she reviewed R1's chart and did not see when the last time R1's catheter was changed at the facility.</p> <p>On 9/27/24 at 1:49 PM, V9 stated she sent R1 to the hospital on 9/18/24 but did not notice the condition of R1's catheter prior to the resident leaving the facility.</p> <p>The Face Sheet dated 9/26/24 for R1 showed diagnoses including osteomyelitis of sacral region, neuropathy, type 2 diabetes, spinal stenosis, transient ischemic attack, obesity, malaise, hypertension, pressure ulcers stage 3 and 4, gastroparesis, dysarthria following cerebral infarction, and major depressive disorder.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/01/2024
NAME OF PROVIDER OR SUPPLIER  Pearl Pavilion		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Order Summary Report dated 9/27/24 for R1 showed 16 french indwelling urinary catheter for stage 3 or 4 pressure injury in the sacral/peri area and neurogenic bladder. The order does not show parameters for changing the catheter. The order for the catheter drainage bag showed it may be changed as needed when unable to observe urine contents in the urinary drainage bag/tubing, presence of gross contamination, obstruction of the catheter or tubing, leaking or malfunction, or as ordered by the physician (schedule as prn (as needed)).</p> <p>The Care Plan dated 7/22/24 for R1 showed, risk for infection or complications related to catheter use. Monitor urine for increase sediment, cloudy urine, odor, blood &amp; output - alert nurse with concerns - call physician with concern.</p> <p>The facility's Catheter Care Policy &amp; Procedure (11/2023) showed, catheters shall be positioned to maintain downhill flow of urine to prevent back flow of urine into the bladder or tubing, during transfer, ambulation, and body positioning. Urinary drainage bags and tubing shall be positioned to prevent from touching the floor. Urinary catheter and tubing will be removed and reinserted when any of the following are observed: a. Inability to observe urine contents in the urinary drainage bag or tubing; b. Observation of gross contamination; c. Obstruction of the catheter or tubing; c. Leakage of malfunction; e. Upon physician's orders. Each resident with an indwelling catheter will receive perineal and catheter care with soap and water during routine care. Encrustations on the indwelling urinary catheter should be removed from the meatus outward with clean wash cloth, rinsed. The date of the catheter insertion shall be documented in the nurses' notes.</p>		