| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145234 | A. Building<br>B. Wing | 03/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pearl Pavilion | 900 South Kiwanis Drive<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39543<br><br>Based on observation, interview, and record review the facility failed to provide incontinence care for residents dependent upon staff for assistance. This applies to 3 of 3 residents (R1, R2, R3) reviewed for nursing care in the sample of 5.<br><br>The findings include:<br><br>1. R3's Admission Record (Face Sheet) showed an admitted [DATE] with diagnoses to include diarrhea, sacral pressure ulcer (top of buttocks), and diabetes.<br><br>R3's 2/9/25 Five Day Medicare A Minimum Data Assessment (MDS) showed he was cognitively intact with a Brief Interview for Mental Status score of 13 out of 15. The MDS showed, he required substantial/maximal assistance for toileting hygiene (the ability to clean oneself after voiding or bowel movement).<br><br>On 3/13/25 at 7:37 AM, V3 and V4 Certified Nursing Assistants (CNAs) stated they were the only CNAs assigned to the first floor.<br><br>On 3/13/25 at 12:15 PM, R3 was in bed watching television. R3 stated he has had diarrhea since November 2024. During the interview, at 12:17 PM, R3 stated he had a bowel movement and turned on his call light. The interview was stopped. R3's call light was illuminated outside his room.<br><br>On 3/13/25 at 12:25 PM, V4 was in the dining room providing feeding assistance and V3 exited the dining room with meal tray cart and began walking down R3's hallway. R3's green call light was still lit.<br><br>On 3/13/25 at 12:27 PM, V3 entered R3's room with his lunch tray, the call light turned off, and V3 exited without the tray. V3 was in R3's room for less than a minute.<br><br>On 3/13/25 at 12:30 PM, R3 was in bed eating his lunch.<br><br>R3's room was directly opposite the surveyor conference room. Continuous observation was maintained from 12:27 PM through 1:10 PM. At 1:02 PM, V4 entered R3's room, picked up his lunch tray and immediately exited the room.<br><br>(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: 145234 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/14/2025 |
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| NAME OF PROVIDER OR SUPPLIER Pearl Pavilion | | STREET ADDRESS, CITY, STATE, ZIP CODE 900 South Kiwanis Drive Freeport, IL 61032 | |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/13/25 at 1:03 PM, R3 stated When [V3] came in, I told her I needed to be cleaned up. She said, 'okay, but you'll have to wait.' I would prefer to be cleaned up before lunch it just feels good to be clean before you eat but there is just not enough staff to get you cleaned up when it's mealtime. I've just gotten used to waiting. (During the interview, at 1:09 PM, someone opened R3's door and closed it.)<br><br>On 3/13/24 at 1:20 PM, V3 said I told him (R3) I would get to him after I passed trays. I told [V4] that he was soiled. I didn't tell anyone else besides [V4]. His call light was on, and he said he had a bowel movement. I told him I would come back. I came back and knocked on the door, but you were in the room (1:09 PM, 50 minutes after he turned on his call light). I'm not going to pass trays after I cleaned up a poopie (soiled) brief; I think that's gross.<br><br>On 3/13/24 at 1:10 PM, V2 Director of Nursing stated if a resident has a bowl movement, they should be cleaned prior to being served their meal tray. V2 said leaving a resident, especially a resident with a history of pressure sores, should not be left to lie in a soiled brief. V2 said it's not hygienic and would not feel too good to eat a meal while sitting in a bowel movement. V2 said, if staff are in the middle of passing trays and they need help, they can ask her or other staff for assistance. V2 said no staff approached her during lunch for assistance.<br><br>The facility Activities of Daily Living Policy (review date of 2/2023) showed Purpose: To preserve ADL (Activities of Daily Living) function, promote independence, and increase self-esteem and dignity. The policy continued, Interventions may include (depending on an assessment based on individualized need) . Maintaining personal hygiene, including planning the task and gathering supplies, combing and/or styling hair, face and hands, brushing teeth, shaving or applying makeup, oral hygiene, self-manicure (safety awareness with nail care), and/or application of deodorant or powder.<br><br>2. R1's Admission Record (Face Sheet) showed and admitted [DATE] with diagnoses to include diabetes, morbid obesity, kidney failure, and heart failure.<br><br>R1's 2/25/25 Medicare Five-day Minimum Data Set (MDS) showed he was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. The MDS showed he was dependent upon staff for toileting hygiene, shower/bathe self, lower body dressing, and personal hygiene.<br><br>On 3/13/25 at 9:45 AM, R1 stated he has only one poorly functioning kidney. R1 stated he needs to drink 3 quarts of water a day to preserve his kidney function. R1 stated because of this he urinates frequently. R1 stated there has been numerous occasions when he has had to wait an hour or more for staff assistance to use the bathroom. R1 said because of the long wait he has had to urinate in his brief instead of using the bathroom. R1 said the longest waits are at shift change. R1 stated he also has transferred himself to the bathroom for bowel movements because of the long waits.<br><br>The Resident Council minutes for January, February, and March 2025 showed call light response times were a concern for the residents.<br><br>3. R2's Face Sheet showed an admitted [DATE] with diagnoses to include morbid obesity, stage four pressure ulcer, and bladder dysfunction.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R2's 3/4/25 Quarterly Minimum Data Set (MDS) showed he was cognitively intact with a Brief Interview for Mental Status Score of 15 out of 15. The MDS showed he was dependent upon staff for toileting hygiene.<br><br>R2's Care Plan showed he was incontinent of bowel and staff should Administer appropriate cleansing and Peri-care after each incontinent episode.<br><br>On 3/13/25 at 8:10 AM, R2 said he uses a brief for his bowel movements then turns on his call light for staff assistance. R2 said the normal for staff to respond to his call light is one hour. R2 said he has had to wait up to 11 hours to be cleaned. R2 said, in that instance, the staff turned off his call light, said they would return, and did not return. R2 said he did not want to bother the staff and press the call light again. R2 said the staff are over worked and he is used to waiting an hour for staff to clean him up. R2 said he would like to be cleaned up sooner than an hour. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39543<br><br>Based on observation, interview, and record review the facility failed to accurately transcribe a resident hospital discharge medication list, failed to follow a physician medication order for narcotics, and failed to follow their policy for controlled substances. This applies to 1 of 3 residents (R1) reviewed for medications in the sample of 5.<br><br>The findings include:<br><br>1. R1's Admission Record (Face Sheet) shows he was admitted on [DATE] with diagnoses to include chronic obstructive pulmonary disease (COPD, a lung disease which leads to decreased lung function and decreased lung capacity).<br><br>R1's 2/25/25 Admission Minimum Data Set (MDS) showed he was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15.<br><br>R1's Hospital Medication list printed on 2/20/25 at 8:42 AM says TAKE these medications: . albuterol sulfate (a medication which dilates the bronchi, the air tubes leading to the lungs) 2.5MG (milligrams)/0.5ML milliliters Nebulizer: 2.5 mg by nebulization route 4 times daily as needed for shortness of breath or wheezing. Indications: spasm of Lung Air Passages Last time this was given: 2.5 mg on February 19, 2025, 7:16 PM<br><br>R1's February 2025 Medication Administration Record (MAR) does not show an order, either active or discontinued, for albuterol nebulizer.<br><br>On 3/13/25 at 9:45 AM, R1 stated his nebulizers help him breath and open his airway.<br><br>On 3/13/25 at 11:20 AM, V2 Director of Nursing stated, while reviewing R1's hospital medication list from 2/20/25, that list of medications would be the medication used by the facility for his admitting medications. V2 said the medications would be entered by a nurse and then, within a few days, the nurse practitioner or physician would approve them. V2 said, while reviewing R1's current and discontinued medication orders, she does not see that the albuterol nebulizer was ever ordered or discontinued. V2 said the most likely scenario is the albuterol was overlooked and not entered into R1's medications for the facility. V2 said the albuterol nebulizer is used to treat shortness of breath and wheezing.<br><br>2. R1's Controlled Drug Receipt/Record/Disposition Form (commonly referred to as a count sheet) for his hydrocodone/acetaminophen (a combined narcotic and an over-the-counter pain medication; commonly referred to as norco) 10-325 milligram tablets showed a dose was dispensed on 3/5/25 at 10:20 PM and 3/6/25 at 5:00 AM. The 3/6/25 dose was dose 30 of 30; the last remaining dose for this norco card. The signature boxes on the count sheet for both Norco doses were blank.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R1's March 2025 Medication Administration Record (MAR) showed his order for norco was for 1 tablet to be given every 6 hours as needed for pain. The MAR showed on 3/5/25 only one dose of norco was documented as being given at 7:34 AM. The MAR showed on 3/6/25 only one dose of norco was documented as being given at 3:19 AM.<br><br>R1's norco Count Sheet beginning on 3/6/25 showed a dose was given at 8:00 AM. The signature for this dose on the count sheet matches the initials documented on the MAR for the 7:34 AM dose. (Within a 10 hour time period, from 3/5/25 at 10:20 PM to 3/6/25 at 8:00 AM three doses of norco were dispensed when only two should have been given per physician orders)<br><br>On 3/14/25 at 9:23 AM, V2 Director of Nursing stated V7 Licensed Practical Nurse was working at 5:00 AM on 3/6/25. (Not the same nurse who dispensed the 7:34 AM dose of norco.)<br><br>On 3/14/25 at 9:23 AM, V2 Director of Nursing (DON) stated, based on the count sheets, R1 should not have been given the 3/6/25 8:00 AM dose, it was too soon. V2 said the possible side effects of too many narcotics would be lowered respiratory rate and lethargy. V2 also said controlled substances should be documented on the MAR and the count sheet. V2 said the MAR is the actual record of when medications are given.<br><br>The facility's Narcotic Controlled Medication Policy (Reviewed 12/2022) showed it should be signed out on the count sheet and documented on the MAR. |