STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145803	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Evanston,the	820 Foster Street Evanston, IL 60201

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. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide needed care and services in accordance with resident's goals for care and professional standard of practice. This deficiency affects one (R3) of three residents reviewed for Quality of care. Findings include: On 8/26/25 at 9:39AM called V11, Family member of R3, regarding complaint presented to IDPH but unable to leave message due to voicemail being full.On 8/26/25 at 9:45AM, V1 Administrator and V2 Director of Nursing (DON) denied complaint allegation of V11 R3 is being left soiled in bed for prolong periods of time.On 8/26/25 at 10:20AM, Observed R3 lying on bed with enteral feeding connected to gastric tube (GT) in progress. R3 was awake but no verbal response. Observed nystatin powder medication 100,000 units per gram labeled with R3's name and instruction of apply under the breast every day as needed and Nystatin and triamcinolone Acetonide cream USP 60 grams not labeled. Both are on top of bedside drawer. V3 WCC (Wound Care Coordinator) said both medications should not be at bedside and should be kept in medication or treatment cart to be applied by the nurse. V3 said medications are only kept it at bedside due to family request. V3 said they could keep treatment medication at bedside if there is a physician order. V3 added R3's daughter applied the medications to R3 when they come to visits. V3 said it should be in included in R3's care plan. R3 is on EBP due to GT and open wound on left foot. Observed bilateral heel protector in placed. R3 is on bariatric bed with LAL (Low air loss) mattress with flat sheet and cloth pad over the mattress. R3 wears disposable adult briefs. V3 WCC said cloth pad was placed over R3's LAL mattress per family request. V3 added it should be in R3's care plan. On 8/26/25 at 10:26AM, V9 CNA (Certified Nurse Assistant) said she is the CNA assigned for R3. V9 said R3 needs total care with ADLs and transfers. They use mechanical lift on her 1x/week to be up on chair for activity. V9 said they need 2 persons to provide care to R3. V9 is aware family installed surveillance video camera in R3's room. She said she has not provided morning care for R3. V9 has not checked R3 since she came in but R3 was changed late by night shift around 9 am. On 8/26/25 at 10:33AM, Observed R3's disposable brief soaked with large amount of loose brown stools and urine. V9 CNA said she has not checked R3 because the night shift provided her incontinence care around 9am- 9:30am. V9 said she is she is going room to room chronologically to provide morning care. V9 said she was recently hired, and this is only her 1st week to this unit. V3 WCC said they should be checking R3 for incontinence every 2 hours. Observed V9 CNA cleanse perineal area and groin area then R3 was repositioned to her right side. V3 WCC cleansed the sacral area. V9 CNA then applied barrier cream with her soiled gloves. Both V9 and V3 said she should change gloves after providing incontinence care and before applying barrier cream to clean buttocks. V9 then took the soiled brief and cloth pads out of the room without removing her PPE (Personal protective equipment) to look for soiled linen cart. V9 removed her gloves and donned new pair of gloves without performing hand hygiene. On 8/26/25 at 10:49AM, Informed V9 of observations made. Both V9 and V3 said V9 should place the soiled brief and cloth pad in a plastic bag, removed the PPE and performed hand hygiene before getting out of the room. Both added V9 should have performed hand hygiene before donning new pair of gloves. On 8/26/25 at 12:23PM, V16 Family member of R3 showed to surveyor Surveillance video camera they installed inside R3's room showing no CNAs provided care to R3 between 6:30am to 10:30am. V16 said her sister V11, called her to go to the facility when she saw from the surveillance video surveyor came with nursing staff observing them providing care to R3. V16 showed 2 nursing employees (1 female without PPE, only wearing gloves and 1 male wearing PPE- mask, gown, and gloves) providing incontinence care to R3 at 6:05 AM to 6:23AM. No one came to check R3 for incontinence not until surveyor came around 10:30am. Surveyor spoke with V11 family member over the phone regarding concerns she called to IDPH. Both denied they requested nystatin powdered and cream medications at bedside. Both also denied they applied the medications to R3. Both denied they requested cloth pad over the mattress. Both said they are aware multi layers of linen will impede the purpose of the LAL mattress. On 8/26/25 at 1:20PM Informed both V1 Administrator and V2 DON (Director of Nursing) of concerns identified. On 8/27/25 at 9:53AM, V21 CNA said she and V22 CNA provided incontinence care to R3 on 8/26/25 around 6:00AM. Both said they are aware the family installed surveillance video camera inside R3's room. V21 said she forgot to wear proper PPE when providing care to R3. V21 is aware R3 is on EBP, and V21 should wear appropriate PPE when providing incontinence care. On 8/28/25 at 10:30AM, V2 DON presented staff in-services for concerns identified for R3. On 8/28/25 at 1:36PM, reviewed facility's video surveillance

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to complete and monitor ongoing Restorative assessment after admission to attain or maintain resident's individual highest functional level. The facility also failed to follow therapy discharge recommendation to Restorative nursing without comprehensive assessment. This deficiency affects one (R1) of three residents reviewed for Restorative Program. Findings include: On 8/26/25 at 10:01AM and at 2:22PM, V19 Family member called regarding her concerns presented to IDPH and left message but did not call back. R1 was admitted on [DATE] with diagnosis listed in part but not limited to Alzheimer's disease, Chronic kidney disease, Disorder of muscle, Dysphagia, Underweight, Protein calorie malnutrition. Restorative admission assessment done on 8/13/24. No succeeding restorative assessment was done since admission. Therapy Physical and Occupational therapy discharge recommendation to restorative nursing on 2/24/25 indicated: Active range of motion exercise, minimal assist for bed mobility, minimal assist for transfer and minimal assist with rolling walker for at least 1 lap for walking. Physician order form as of 7/24/25 did not indicated that R1 was on restorative program. Most recent MDS/resident quarterly assessment section O Special treatment and programs 0500 Restorative Nursing Programs indicated: Active range of Motion (AROM) marked 6 days Walking marked 6 days. Reviewed R2's restorative log 7 days prior to discharged from the hospital indicated that staff still marked participated in AROM and walking program on 7/25/25 despite R2 was discharged to hospital on 7/24/25. The restorative log indicated that R2 did not participated in program from 7/17/25 to 7/24/25 except for 7/23/25 which staff indicated that he participated for both AROM and walking but there was discrepancy because of nursing progress notes dated 7/23/25 indicated R1 was very weak, lethargic and failure to thrive. Comprehensive care plan indicated R1 needs to maintain ROM trough self-performance related to cognitive deficit and risk of fall. R1 exhibits decreased in ability to dress self-related to decline cognition. R1 has an ADL (Activity of daily living) self-care performance deficit related to Alzheimer's, fall risk, impaired balance. R1 needs assistance to ambulate and would benefit from ambulation program to maintain current abilities related to disorder of muscle. R1 demonstrates cognitive impairment related to dementia. R1 has communication challenges due to dementia. R1 has nutritional problem or potential nutritional problem related to medical history. R1's care plan interventions were not updated since admission. On 8/27/25 at 9:59AM, V4 Restorative Nursing denied complaint allegations presented by V19 Family member/daughter of R1 that the facility failed to maintain mobility post rehab despite of repeated family request and lack of an active restorative /mobility plan in the facility. Reviewed R1's medical records with V4 which indicated that V4 only did initial/admission restorative assessment of R1 on 8/13/24. V4 said he forgot to do follow up assessment as indicated in their policy. V4 said restorative assessment is done upon admission, quarterly, annual, and as needed. R1 was on ROM and walking program during her stay in the facility. V4 said he only selected 2 programs from therapy discharge recommendations to Restorative nursing. V4 said he did not complete restorative assessment when R2 was discharged from therapy to Restorative nursing. On 8/27/25 at 2:00PM, Informed V1 Administrator and V2 DON of concerns identified with Restorative program, On 8/28/25 at 11:30Am, Reviewed facility's policy on Restorative program and informed concerns identified with V4 Restorative Nurse. Facility's policy on Restorative Nursing Program reviewed 8/18/24 indicated: Intent: it is the policy of the facility to assist each resident to attain and or maintain their individual highest most practicable functional level of independence and well-being, in accordance with State and federal regulations. Procedure: 1. Each resident will be screened and or evaluated by the Nurse designated to oversee the Restorative nursing process for inclusion into the appropriate facility restorative nursing program when it has been identified by the interdisciplinary team that the resident is in need or may benefit from such programs. 2. The facility restorative nursing program will include but not limited to the following programs: a. Hygiene- bathing, dressing, grooming and oral careb. Mobility- transfer and ambulation, including walking, prosthetic and or splintc. Elimination- toileting, bowel, and bladderd. Dining- eating, including meals and snackse. Communication- including speech language, other functional communication systems.4. The above program will be documented on the facility designated restorative care forms/tools in the resident's electronic medical record. 5. Based on clinical evaluation and ongoing consideration residents may be placed in one or more of the above listed programs at one time.6. The designated nurse will be responsible for the following: a. Obtaining orders for the resident's restorative programb. Documentation monthly (at a minimum) and c. Initiation and updating