

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146034	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER Pearl at the Tillers		STREET ADDRESS, CITY, STATE, ZIP CODE 4390 Route 71 Oswego, IL 60543	

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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43389</p> <p>Based on interview and record review the facility failed to follow physician's order for oxygen administration.</p> <p>This applies to 1 of 3 residents (R1) reviewed for oxygen use in the sample of 4.</p> <p>Findings include:</p> <p>R1's EHR (Electronic Health Record) documents R1 is a [AGE] year old female who was admitted to the facility on [DATE], with diagnoses that include Chronic Respiratory Failure with Hypoxia, Morbid obesity, Muscle Weakness, Heart Failure, Obstructive Sleep Apnea, shortness of Breath and Pulmonary Arterial Hypertension. R1's MDS (Minimum Data Set) dated September 30, 2024, shows R1 is alert and oriented and was cognitively intact.</p> <p>R1's EHR also shows a physician's order dated September 27, 2024, to administer Oxygen 2 Liters continuously for hypoxemia.</p> <p>On October 8, 2024, at 9:52 AM and October 9, 2024, at 3:30 PM, R1 stated on the day she was admitted to the facility, the oxygen concentrator they had for her did not work properly so they put her on a portable oxygen tank. R1 stated, the oxygen tank ran out of oxygen in a couple hours, and someone came and put her on a second oxygen tank. In the meantime, another concentrator was delivered. R1 stated that the second oxygen tank was running out and the nurse needed to come and put her on the oxygen concentrator. R1 stated V3 (Certified Nursing Assistant/CNA) could not hook her up to the oxygen concentrator. R1 stated she could not get up to do it by herself. R1 stated the CNA (V3) was very nice and kept telling the nurse that the oxygen was going to run out and eventually it did. R1 stated, the nurse still did not come. R1 stated she panicked because she did not have oxygen for over 2 hours. R1 stated she then called a family member who lives nearby and asked him to come over to put her oxygen on and he did come around 9:00 PM. R1 stated her family member took the concentrator out of the wrapping, adjusted the settings, switched her nasal cannula from the portable oxygen tank to the oxygen concentrator, and plugged it into the wall. R1 stated V4 (her assigned nurse) did not come in until after her family had left.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On October 8, 2024, at 12:17 PM and on October 9, 2024, at 3:30 PM, V3 (CNA) stated she remembers R1 and the issue with her oxygen on October 9, 2024. V3 stated R1 needed some oxygen. V3 stated the CNAs are not allowed to do anything with the oxygen, they can't turn on or adjust it. V3 stated she told V4 (Registered Nurse) and V5 (Nursing Manager) several times that R1 needed oxygen. They both said they will go do it, but they never did. V3 stated she felt bad for the resident and kept checking on R1. V3 stated R1's oxygen was off for a long time, but she was not sure for how many hours the oxygen was off. V3 stated later that evening a gentleman came in to see R1. V3 stated he came and put R1's oxygen concentrator on. V3 stated, he said he just unwrapped it and plugged it in. V3 stated that the oxygen concentrator that her family put on her worked fine.</p> <p>R1's grievance dated September 28, 2024, showed that R1's oxygen concentrator that was ordered was not functioning properly, and R1 was put on an oxygen tank.</p> <p>On October 8, 2024, at 5:15 PM, V2 (Director of Nursing) stated they she expects staff to follow the physician's orders.</p>		