STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003339	A. BUILDING: _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL PAVILION	900 SOUTH KIWANIS DRIVE FREEPORT, IL 61032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 5 Findings 300.610a) 300.1210a) 300.1210b)5) 300.1210d)5 300.1220b)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 300.1210 Section General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not	S9999		

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S9999	Continued From page 2 develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These Regulatins were not met as evidenced by: Based on observation, interview, and record review the facility failed to implement interventions to promote wound healing; failed to assess a pressure injuries upon readmission; and failed to implement treatment for a pressure injury upon readmission. The facility also failed to provide care in a manner to prevent pressure injury cross- contamination. This applies to 3 of 7 residents (R51, R23, R10) reviewed for pressure ulcers in the sample of 23.	S9999		

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S9999	Continued From page 3	S9999		

This failure resulted in R51's pressure ulcers not being assessed or treated upon readmission leading to a worsening of R51's pressure injury.

The findings include:

1. R51's Face Sheet showed an original admission date of 7/15/22 with diagnoses to include: Right pubic fracture (onset 12/27/22); Non-Pressure chronic ulcer of right and left lower leg; heart failure.

R51's 1/8/23 Minimum Data Set (MDS) showed she was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. R51's MDS showed she required extensive assistance of two staff for bed mobility, transferring, dressing, and toileting.

R51's Pressure Injury Report showed she had an unstageable pressure injury to her left heal measuring 1.1 centimeters (cm) by 1.3 cm by 0.1 cm. The report showed the right heel was also unstageable measuring 0.9 cm by 1.1 cm by 0 cm. The pressure injury report showed it was identified in this condition on 2/23/23 and the last assessment was 2/23/23. (Document was provided on 3/9/23 at 11:23 AM.)

R51's Skin/Wound Note from 2/23/23 at 8:26 PM showed she has blisters to the left lower leg that burst open and "Eschar" (dead tissue) to both heels. The note showed the same measurements as the pressure injury report from 2/23/23. The note showed she applied a betadine (antiseptic) moistened 4 inch by 4 inch gauze pad, an absorbent pad (ABD), and a gauze wrap. The note showed, "I put pillows under her feet to help relieve pressure."

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S9999	Continued From page 4	S9999		

R51's Skin/Wound note from 2/16/23 showed no heel injuries.

R51's 2/27/23 Progress note from 2:24 PM showed she was sent to the local emergency department for increased confusion and swelling to her legs.

R51's 3/3/23 Social Service note from 2:02 PM showed she returned to the facility.

On 3/7/23 at 2:20 PM, R51 had signage on her door indicating she was in contact and droplet isolation. R51 was supine in bed. R51 had gauze wrap to her lower leg extending to the middle of her foot. The gauze wrap was covered with an elastic support bandage. R51 had a blanket folded under her ankles; however, R51's heels were touching the bed.

R51's March 2023 TAR (provided 3/9/23) showed her heel treatment was discontinued on 3/2/23. R51's TAR showed no heel treatment was documented as being provided.

On 3/8/23 at 11:48 AM, R51 was supine in bed. Heels in full contact with the mattress; no blanket under her ankles.

On 3/9/23 at 8:34 AM, R51was supine in bed and her heels were in full contact with the mattress.

On 3/9/23 at 8:34 AM, R51 stated she has not been out of bed since she returned from the hospital. R51 said, "I guess I'm lucky I have water. They don't care about me here."

On 3/9/23 at 9:51 AM, V7 Licensed Practical Nurse (LPN) stated if there are not orders for

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S9999	Continued From page 5	S9999		

wound care she wouldn't know that the treatment needed to be done.

On 3/9/23 at 9:55 AM, R51's heels remained in full contact with her mattress. Her room was as it was at 8:34 AM; over bed table to the side, no breakfast tray in the room.

On 3/9/32 at 9:55 AM, R51 stated, "I never got my breakfast. I'm starving please just get me a cracker or something."

On 3/9/23 at 10:10 AM, V1 Administrator stated there is a camera on R51's hallway. (Requested V1 review video showing staff provided R51 a breakfast tray; no video proof was provided.)

03/08/23 11:19 AM, V28 Registered Dietician said proper nutrition and protein is important for wound healing.

On 3/9/23 at 10:49 AM, V7 and V14 Certified Nursing Assistant (CNA, providing assistance for V7) entered R51's room for wound care. V7 removed the bandage to R51's right lower leg and stated there is no wound to the right heel. The dressing removed from R51's left heel did not include a betadine moistened gauze or an absorbent pad (ABD.) V7 removed the wrap to R51's left lower leg and said there is a heel wound and she has no orders to treat this wound. R51 refused to have her legs wrapped again. R51 stated she wanted to leave them off for a while because they make her legs hot. V7 did not provided education or encouragement to R51 regarding the importance of wound care and protecting her wounds. V7 also did not offer alternative options to protect R51's wound. At 11:03 AM V7 and V14 completed their care and left the room. R51's left heel draining pressure

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S9999	Continued From page 6 injury was in full contact with the bed; her heels were not off-loaded. On 3/09/23 at 10:49 AM, R51's left heel was approximately 3 inches by 2 inches (7.6 cm by 5 cm; wound is considerably larger compared to 2/23/23 assessment.) On 3/09/23 at 11:03 AM, R51 stated, "If they had a pillow, I would let them get my heels off the bed. That would probably feel good. I think they are supposed to have my heels not touching the bed anyways." On 3/09/23 at 11:20 AM, V2 Director of Nursing stated, (while reviewing R51's electronic record) she could not find any treatment orders for R51's left heel. V2 stated, "It (R51's left heel pressure injury) was first identified to left heel on 2/23/23 per the wound report. It was found as an unstageable pressure wound. I would expect her wound to be found prior to it having eschar, which is dead tissue. I don't see any other assessment other than 2/23/23." V2 said R51's wound should have been assessed upon her return from the hospital on 3/3/23. (R51's wound had not been assessed by the facility as of 3/9/23 at 11:20 am; 6 days later.) V2 said R51's heels should be off-loaded to promote wound healing. V2 said an indicator of a wound declining is increasing in size, smell, or pain. V2 said wound orders are important to ensure the best wound care to promote healing is put in place; ensures the physician is aware of the resident's current status; and it ensures the wound treatment is being done. V2 said the importance of wound assessments is to track the wound to determine if the wound is declining, which may warrant a change in wound care. V2 said the only location R51's wound treatment would be documented is	S9999		

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S9999	Continued From page 7 in the wound report and/or her treatment administration record. R51's Care Plan showed, "Skin will be checked during routine care on a daily basis and during the weekly bath or shower schedule per resident preference." R51's care plan showed no interventions to off-load her heels. R51's February 2023 Treatment Administration Record (TAR) showed both heels should be cleaned and dried; betadine moistened gauze applied; and then covered with gauze and an ABD pad. The TAR showed this treatment was not initiated until 2/26/23 (3 days after wound was identified.) R51's Wound Policy (Revised 2/2023) showed finding from the weekly skin assessment should be completed by the wound nurse or designee and "should cover all pertinent characteristics of existing ulcers, including location, size, depth, maceration, color of the ulcer and surrounding tissues..." The policy showed, "Nursing staff should keep the attending physician aware of the progress of all ulcers, especially those in higher risk residents, those that do not heal as anticipated, and those that develop complications..." 2. R23's face sheet showed he was admitted to the facility on 2/1/22 with diagnoses to include acute on chronic congestive heart failure, chronic atrial fibrillation, difficulty in walking, unsteadiness on feet, essential hypertension, gall bladder disease, Type 2 Diabetes, and major depressive disorder. R23's facility assessment dated 2/15/23 showed he has severe cognitive impairment and requires extensive assistance from staff for all cares.	S9999		

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S9999	Continued From page 8 R23's nursing note dated 11/30/22 showed, "I was called to resident room. CNA was cleaning resident's toes and there is an area between great and 2nd toe. It appears to be a stage 2. Right foot. It was cleansed and protocol initiated. Wound nurse was notified." R23's Skin/Wound note dated 11/30/22 entered at 6:36 PM showed, "... Resident has an opening on the top of the toe. The third toe is rubbing the skin off. Wound measures 0.9 x 1.6 x 0.1 cm..." R23's November 2022 TAR (Treatment Administration Record) showed no orders for wound care to R23's 2nd toe. R23's December 2022 TAR showed an order for treatment to R23's 2nd toe on his right foot was not started until 12/6/22 (6 days after identification). On 3/8/23 at 2:33 PM, V15 (Wound Care Nurse) entered R23's room to provide wound care to the pressure sore on R23's right foot. V15 entered the room and went directly to R23's bed. V15 did not perform hand hygiene prior to starting R23's wound care. V15 applied gloves, sprayed the wound with wound cleanser, cleaned the wound with gauze, removed her gloves (did not perform hand hygiene), put on a new pair of gloves and put the new dressing on. V15 then removed her gloves, picked up the wound supplies, exited R23's room and went to the clean utility room where she washed her hands. V15's heels were not floated prior to V15 leaving the room. On 3/09/23 at 11:57 AM, V2 DON (Director of Nursing) said hands should be washed after entering the room and before touching the resident. V2 said gloves should be put on and changed after the wound is cleaned and before	S9999		

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S9999	Continued From page 9	S9999		

putting the new dressing on. V2 said gloves should be changed during the wound care but no hand hygiene is necessary due to time restrictions while performing dressing changes. V2 said V15 should have washed her hands before leaving R23's room.

The facility's policy and procedure revised 11/8/22 showed, "Hand Hygiene; Purpose: Provide guidelines on proper and appropriate hand washing and hygiene techniques that will aid in the prevention of the transmission of infection... Procedure: ... 3. The use of gloves does not replace hand hygiene. 4. Hand hygiene is always the final step after removing and disposing of personal protective equipment (PPE)... Staff will perform hand hygiene by washing hands for at least twenty seconds with antimicrobial or non-antimicrobial soap and water under the following conditions: ... c. Before applying gloves and after removing gloves or other PPE; d. After contact with blood, body fluids, secretions, mucous membranes, or non-intact skin; e. After handling items potentially contaminated with blood, body fluids, or secretions; ...g. After providing direct resident care... "

3. R10's Admission Record, printed by the facility on 3/8/23, showed diagnoses including encephalopathy (a term for any brain disease that alters brain function or structure), other specified disorders of the brain, convulsions, bipolar disorder, autistic disorder, disorders of psychological development and altered mental status. R10's ADL (activities of daily living) care plan, with a revision date of 3/10/22. showed she had a self-care deficit and required total assistance of staff in all aspects of hygiene and dressing. R10's facility assessment dated 12/9/22 showed she had severe cognitive impairment and

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S9999	Continued From page 10	S9999		

was dependent on staff for personal hygiene. The assessment showed R10 was always incontinent of bowel and bladder. R10's incontinence care plan, with a revision date of 1/4/21, showed she had incontinence of bowel and/or bladder. The care plan showed "Administer appropriate cleansing and peri-care after each incontinent episode. Observe for signs of skin irritation and/or breakdown..." R10's skin integrity care plan, with a revision date of 10/12/21, showed she is at increased risk for alteration in skin integrity and skin will be checked during routine care on a daily basis..." R10's Order Summary Report, showing active orders as of 3/8/23, showed "Cleanse coccyx with normal saline, pat dry. Apply foam dressing twice weekly." R10's 2/20/23 Skin/Wound note showed "Resident has an open stage II to the left inner buttock cheek. The wound has a red outer edge. Full thickness wound with no drainage. Area measures 0.4 x 0.8 x 0.1 cm (centimeters)..."

03/06/23 at 7:43 PM V17 and V18 (Certified Nursing Assistants-CNAs) were providing incontinence care during the bedtime care for R10. V17 cleaned R10's front, periarea, then rinsed and dried. V17 and V18 rolled R10 onto her right side. R10 had a couple small pieces of stool in her brief. V17 used the same wash cloths that she used to clean R10's periarea to wipe and rinse both of R10's buttock cheeks, then the rectal area, then wiped over the open wound on R10's left inner buttocks. V15 (Wound Nurse) came into R10's room and placed a dry dressing over the open area on R10's left inner buttocks. V15 did not clean the wound before placing the dressing on.

On 3/09/23 at 9:03 AM, V29 (Licensed Practical

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S9999	Continued From page 11 Nurse-LPN) said it is not okay to clean a resident during pericare and then wipe over the open wound bed, it is cross-contamination. V29 said the staff should use a clean cloth to clean the wound bed. On 3/9/23 at 10:12 AM, V2 (Director of Nursing-DON) said she would expect the CNAs to use a clean wash cloth for each area during incontinence care. At 10:20 AM, V2 said staff should not clean stool and then go over any wound bed with the same cloth. V2 said staff should not use the same wash cloth to clean the front and back areas of the resident during incontinence care and then go over a wound bed because it would introduce bacteria into the wound bed. The facility's Wound Policy, with a revision date of 2/2023, showed "Purpose... To promote healing of existing pressure and non-pressure ulcers. " The policy showed "5. The goals of wound treatment are to; a. Keep the ulcer bed moist and the surrounding skin dry. b. Protect the ulcer from contamination, and c. Promote healing." (B) 2 of 5 300.1010h) 300.1210b) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health,	S9999		

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S9999	Continued From page 12 safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 300.1210 Section General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. These Regulations were not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a resident on an enteral feeding did not experience severe weight loss, failed to provide enteral feeding per facility policy and procedure, and failed to follow the physician's order for enteral feeding for 1 of 2 residents (R9) reviewed for enteral feedings. This failure resulted in R9 experiencing a severe weight loss of 28 lbs in three months which is a 13% weight loss. The findings include: R9's face sheet showed he was admitted to the facility on 1/6/23 with diagnoses to include	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13 cellulitis of bilateral lower extremities, major depressive disorder, and pressure ulcer of right buttock stage 3. R9's facility assessment dated 1/13/23 showed he has no cognitive impairment and is totally dependent on staff for all cares. R9's care plan initiated 1/10/23 showed, "The resident is receiving a tube feeding and it has been determined to be medically necessary and the resident is at risk for complications: ... inadequate calorie or protein intake, altered hydration... Goal: The resident will tolerate the tube feeding without complications thru the next review... Interventions: ... The feeding tube will be utilized in compliance with current clinical standards of practice and services provided to prevent complications to the extent possible for the resident... Report the following to the MD (physician) for further medical evaluation: ... changes in medical condition... weight loss..." On 3/06/23 at 6:09 PM, R9 said he has lost a lot of weight since being at the facility. R9 said his pants are falling off of him. R9's record showed the first time the Registered Dietitian assessed R9 was on 1/21/23. This assessment showed, "... Chart reviewed for new admission, skin review, and tube feeding follow up- noted that resident does not have orders for free water flush to meet hydration needs. RD (Registered Dietitian) to provide recommendations to clarify orders and increase protein to aid in wound healing. Tolerating TF (tube feeding), however, some noted refusals due to feeling full. Will encourage staff to notify RD if resident is not tolerating... PLAN: Continue to monitor with RD available as needed. Recommendations: 1) update TF orders to read: Jevity 1.2 bolus feed of 480 mls four times per	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003339	A. BUILDING: _____ B. WING _____	03/09/2023

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S9999	Continued From page 14	S9999		

day to Total Volume 1920 ml/24 hours; 2) Provide Free Water Flush: 200 ml four times per day to total volume 800 ml/24 hours; 3) Provide via PEG: Prostat 30 mls BID to aid in wound healing..."

R9's Dietary Progress note dated 2/10/23 showed, "... Resident triggered for significant weight loss x 1 month [-11%, -23.6 pounds] - per nursing notes, resident has been reported to skip bedtime bolus feed resulting in decreased caloric intakes. Staff encourage resident to take bolus, however he will refuse.... Chart reviewed for skin review and tube feeding follow up and significant weight loss review... Plan: Continue to monitor with RD available as needed..."

R9's January 2023 MAR (Medication Administration Record) showed R9 refused 9 of 24 of his enteral feedings scheduled to be given at 9:00 PM. R9's February 2023 MAR showed R9 refused 20 of 28 of his feedings scheduled for 9:00 PM. R9's March 2023 MAR showed R9 refused 4 of 7 of his feedings scheduled at 9:00 PM.

R9's weight record was reviewed and showed on 1/6/23 he weighed 213 pounds, on 2/6/23 he weighed 190 pounds, and on 3/8/23 he weighed 185 pounds. (This is a 13% weight loss in three months.)

R9's Physician Order Sheet showed an order started 1/6/23, "Enteral Feed Order, four times a day 16 ounce bolus feeding plus 21 grams protein and probiotic". The same Physician Order Sheet showed, "Jevity 1.2 bolus feed of 480 mls four times a day to Total Volume 1920/ml over 24 hours." R9's physician order sheet did not include the addition of the free water flush recommended

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003339	A. BUILDING: _____ B. WING _____	03/09/2023

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S9999	Continued From page 15	S9999		

by the Registered Dietitian to meet R9's hydration needs. The same Physician Order Sheet showed an order started 1/29/23 for ProStat (protein supplement) twice daily.

On 3/7/23 at 8:36 AM, V15 WCN (Wound Care Nurse) prepared R9's medications and placed them in a small drinking cup and poured water over them. V15 did not include Pro-Stat (protein supplement) with R9's medications. V15 mixed them with a spoon and entered R9's room. V15 did not wash her hands after she entered R9's room, filled a graduated cylinder with water from the bathroom and went to R9's bedside. V15 went into R9's closet and brought out a enteral feeding syringe. No hand hygiene was performed. V15 asked R9 if he wanted some protein today to which he answered "yes". V15 took a scoop of protein powder from the large container of protein powder at bedside and placed a full scoop into the same cup with R9's medications and water. V15 stirred the mixture for several minutes to try and get the protein powder dissolved. The cup was full all to the top edge. V15 filled the enteral feeding syringe from the cup, opened the valve on R9's enteral tube and pushed the contents into his tube without checking placement. V15 repeated this for 15 syringe's full of medications, water, and his carton of tube feeding formula. V15 was adding water and formula to the cup to try and get all the medications and protein from the cup. No hand hygiene was performed before leaving R9's room.

R9's complete medical record showed no evidence of notification to R9's physician regarding significant weight loss.

On 3/09/23 at 11:57 AM, V2 DON (Director of Nursing) said in order for R9 to receive protein

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003339	A. BUILDING: _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 16	S9999		

powder he should have an order for protein powder. V2 said ProStat is a protein supplement and since he has an order for the ProStat he should have received the ProStat. V2 said the facility has been trying with his comorbidities but he has declining rapidly. V2 said the facility has received recommendations for a continuous feeding but the family refuses. V2 said she was not aware of R9's continuous refusals for his nightly enteral feeding. V2 said she has told the nursing staff to do R9's feeding first thing in the morning because he is very hungry in the morning. V2 said R9's physician and nurse practitioner have been coming in every week for the previous month. V2 said the Nurse Practitioner and the Physician both document in the electronic record when they see a resident. V2 was unable to provide documentation to show R9 was seen by the Nurse Practitioner or the Physician since his admission to the facility. V2 said R9 goes to many physicians and all have recommended the same continuous feeding. The only documentation provided to show R9's physician visits was emergency room visit documentation. V2 said V15 (Wound Care Nurse) should have washed her hands upon entered R9's room and upon exiting after providing care. V2 said V15 should have checked placement prior to pushing the medications and tube feeding formula to ensure proper placement of the tube. V2 said R9's orders should reflect the free water flush to avoid dehydration.

On 3/9/23 at 2:06 PM, V28 (Registered Dietitian) said residents who have enteral feeds are assessed monthly. V28 said they were aware of R9 refusing some of his nightly feedings but that they were not aware that he was refusing almost all of his nightly feedings. V28 said if they knew he was refusing these feedings so frequently they

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	IL6003339	A. BUILDING: _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 17 would have considered adjusting the other three scheduled feedings to increase his caloric intakes. The facility's policy reviewed 4/2022 showed, "Tube Feeding; Purpose: To define infection control measures for the resident receiving tube feedings. Standards: 2. Wash hands before and after the procedure... 10. After each tube placement check, before and after medications and feedings, the tube is flushed with clear water (patency check) to completely clear the tube to remove all residues..." The facility's policy reviewed 11/22 showed, "Change in Resident's Condition... General: It is the policy of the facility, except in a medical emergency to alert the resident, resident's physician/Nurse Practitioner and resident's responsible part of a change in condition.... Policy: 1. Nursing will notify the resident's physician or nurse practitioner when: ... b. There is a significant change in the resident's physical, mental, or emotional status. c. There is a pattern of refusing treatment or medication. The facility's policy reviewed 11/22 showed, "Weighing Residents; Purpose: To monitor weight gain or loss.... 1. Ease resident is weighed on admission and monthly thereafter, or in accordance with physician orders or plan of care. 5. A licensed nurse evaluates weight changes and determines if there is a 3 pound or greater weight loss/gain in one week and notified physician of unanticipated or undesired weight gain or loss. 7. Monthly weights shall be measured and recorded according to schedule. Undesired or unanticipated weight gains/loss of 5% in 30 days, 7.5% in three months, 10% in six months shall be reported to the physician, Dietary	S9999		

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S9999	Continued From page 18 Manager and or Registered Dietitian..." (B) 3 of 5 300.610a) 300.1010h) 300.1210a) 300.1210b)5) 300.1210c) 300.1210d)2)3) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The	S9999		

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S9999	Continued From page 19 facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 300.1210 Section General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest	S9999		

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S9999	Continued From page 20 practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as	S9999		

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	IL6003339	A. BUILDING: _____ B. WING _____	03/09/2023

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PEARL PAVILION	900 SOUTH KIWANIS DRIVE FREEPORT, IL 61032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 21 indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on observation, interview, and record review the facility failed to monitor a resident's weight who had congestive heart failure; failed to provide wound care in a manner to prevent cross contamination; and failed to provide ongoing assessments for a resident readmitted following a pulmonary embolism. This applies to 4 of 5 residents (R11, R29, R54, R1) reviewed for quality of care in the sample of 23 and 1 resident (R20) outside of the sample. This failure resulted in R11 being hospitalized for an exacerbation of congestive heart failure and chronic obstructive pulmonary disease. The findings include: 1. R11's Face Sheet showed an original admission date of 9/9/2019 with numerous diagnoses to include: congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, and morbid obesity. R11's 12/21/22 Minimum Data Set (MDS) showed he was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. R11's MDS showed he required limited assistance of one person for transfers and dressing as well as	S9999		

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	IL6003339	A. BUILDING: _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 22 extensive assistance of one person for toilet use and personal hygiene. On 3/06/23 at 7:42 PM, R11 was in his room, in his wheelchair, and self-propelling in his room. R11 was using supplemental oxygen via nasal cannula set to 5 liters per minute. R11 stated, "I just got back from hospital today. I was there for five days. I have CHF and I was having trouble breathing for several weeks and I just couldn't take it anymore. They (hospital) took 14 liters [of fluid] off of me. I can breathe better now. They (facility) never weigh me. I've only been weighed a few times since I've been here...I don't think the staff recognized what the problem was...Everyone knew I was having breathing difficulties. I told everybody that. I even told the activity lady. The activity lady took my oxygen saturation. It's just that no one was pushing me to go to the hospital except myself." R11's hospital discharge summary from 3/6/23 showed during his hospital stay "Continue bumex (diuretic) gtt (intravenous drip) and albumin (intravenous protein) for exacerbation of CHF." The summary showed he was down 7 liters of fluid. R11's electronic health record showed he was sent to the hospital on 3/1/23. R11's progress notes showed no entries on 3/1/23. R11's electronic health record showed no documented assessment on 3/1/23. R11's 3/6/23 Nursing Progress Notes from 2:25 PM showed he readmitted to the facility at 1:45 PM (5 day hospital admission). R11's Weights and Vitals Summary from 11/1/22 through 2/31/23 showed the following (only 4	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003339	A. BUILDING: _____ B. WING _____	03/09/2023

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PEARL PAVILION	900 SOUTH KIWANIS DRIVE FREEPORT, IL 61032

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S9999	Continued From page 23	S9999		

weights): on 11/30/22 he weighed 232.4 pounds; on 12/1/22 he weighed 248 pounds; on 1/26/23 (nearly two months between weights) he weighed 249.4 pounds; on 2/1/23 he weighed 250 pounds (This was the final documented weight prior to R11's hospital admission.) R11's documented weight on 3/7/23 was 271 (21 more pounds than the previous weight) pounds. (This weight is following a hospital stay in which 7 liters of fluid, or 15.4 pounds was removed.)

R11's 2/26/23 Dietary progress note for 10:57 PM showed his chart was reviewed and he triggered for significant weight gain of 17.6 pounds or 7.6 percent over 3 months (From his weight of 232.4 pounds on 11/30/22 to his weight of 250 pounds on 2/1/23) The note showed R11 had a diagnosis of CHF and he was on diuretic therapy, which may be attributing to his weight fluctuations. (The note did not indicate R11's provider was notified of the weight gain. This note was documented 25 days after he was weighed on 2/1/23. Note was authored by V28 Registered Dietitian.)

On 3/08/23 at 11:19 AM, V28 stated she did not recall R11. V28 stated CHF resident are "...at risk for fluid gain or fluid loss from week to week typically they are weighed weekly; depending on doctor orders. I would expect the doctor to be notified [of weight gain] because they might need an increase in their diuretics. I think it's possible that maybe he (R11) would not have needed to be admitted [to the hospital] if the MD was notified and the diuretic was increased."

On 3/08/23 at 3:38 PM, V2 Director of Nursing stated, she could not find any assessment or documentation regarding why R11 was sent to the hospital. V2 stated she would expect a "head-to-toe" assessment if a resident is

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	IL6003339	A. BUILDING: _____ B. WING _____	03/09/2023

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S9999	Continued From page 24	S9999		

complaining of shortness of breath. V2 said, "They (the hospital) ended up keeping him for 5 days which, means it was fairly significant. CHF patients can get fluid around their lungs and that can cause shortness of breath. Weighing should be done weekly for CHF to monitor for fluid increase. They should have seen the weight increase way before (2/26/23). The second they (resident) put on the weight it should have been identified." V2 said if weight gain is identified, "They should call the doctor as soon as it notified and assess the resident." V2 said, if weekly weights were done and the doctor was notified of R11's weight gain, she would anticipate an increase in R11's diuretic dosing or a new diuretic medication. V2 said these interventions could have prevented R11 from experiencing shortness of breath and a subsequent 5 day hospital admission.

The National Library of Medicine published study titled Information Needs of Skilled Nursing Facility (SNF) Staff to Support Heart Failure Disease Management (published 1/25/21) showed, monitoring body weight, administering medication, and sodium restricted diets "Improved outcomes of patient with HF (heart failure) in skilled nursing facilities...Evidence shows that performing heart failure disease management (HF-DM) practices as described by clinical guidelines can decrease mortality rates, decrease hospital admission rates, and improve quality of life for HF patients by relieving symptoms. However, within the SNF, quality of HF care is highly variable and HF-DM practices are applied inconsistently...Clinical practice guidelines recommend monitoring for changes in body weight and changes in symptoms because these early warning signs can alert staff and physicians to worsening HF, prompt early

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PEARL PAVILION	900 SOUTH KIWANIS DRIVE FREEPORT, IL 61032

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S9999	Continued From page 25 intervention, and may help patients avoid hospitalizations..." 2. R29's Face Sheet showed an original admission date of 4/12/2019 with diagnoses to include: chronic ulcer of right heel and midfoot; diabetic foot ulcer; and type 2 diabetes. On 3/07/23 at 1:45 PM R29's was supine in bed with an elastic bandage and wound vacuum to his right foot. On 3/7/23 at 1:45 PM, V15 wound care nurse removed R29's dressing to his right heel by cutting the elastic bandage as well as the underlying dressings and then removed his negative pressure wound therapy NPWT (commonly referred to as a wound vac) tubing. V15 set the scissors in R29's bed. V15 then cleaned the wound and applied the NPWT dressing; during this time V15 did not change her gloves until after R29's drape dressing was applied. V15 did not sanitize her scissors prior cutting the new NPWT drape and foam dressing components (same scissors used to cut the old dressing then set in R29's bed.) On 3/08/23 at 4:09 PM, V2 Director of Nursing stated V15's gloves should have been changed after R29's dressing was removed and before the wound was cleaned. V2 said this is done to prevent cross-contamination of the wound. V2 said V15's scissors should have been disinfected prior to cutting R29's clean NPWT drape and foam. V2 said her scissors could have been contaminated from cutting the old dressing and/or setting them down in the resident's bed 3. R54's Admission Record, printed by the facility on 3/8/23, showed diagnoses including cellulitis of	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003339	A. BUILDING: _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL PAVILION	900 SOUTH KIWANIS DRIVE FREEPORT, IL 61032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 26	S9999		

left and right lower limbs, morbid obesity, dyspnea and arthropathies (diseases of the joints i.e. arthritis). R54's most recent facility assessment showed she is cognitively intact (BIMS score of 15) and is independent with activities of daily living. The assessment showed R54 does require supervision for dressing and personal hygiene. R54's Admission/Readmission Screener dated 11/19/22 showed "Skin Integrity: 1. Current ski integrity issues: Venous or arterial ulcers." The screening document also showed R54 had +1 pitting edema to her bilateral lower extremities. R54's 11/19/22 Discharge Summary, from a local hospital, lists self neglect as one of her discharge diagnoses.

On 3/6/23 at 6:08 PM, R54 was sitting in her room, in her wheelchair. Both of R54's lower legs were covered in bandages. Both of R54's feet were swollen and her right foot was very red. R54 said she has infections in both legs. R54 said she changes the bandages on her legs herself. R54 opened the drawer to her night stand and it was filled with supplies to do the dressing changes.

On 3/8/23 at 11:08 AM, R54 was sitting in her wheelchair in her room, doing needlepoint. R54 put the needlepoint down and got the supplies out of the bottom drawer of her night stand to do the dressing change. R54 cut the gauze that was wrapped around her right leg and removed the gauze. R54 did not perform hand hygiene or wear gloves at any point during the wound care. R54 had oil emulsion dressings around her right lower leg. R54 said she put them on that morning so she was not going to change them as she already had and they were to be changed daily. R54 put saline on gauze and patted the oil emulsion dressing with the gauze. Then R54 put a little more saline on another piece of gauze and wiped

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003339	A. BUILDING: _____ B. WING _____	03/09/2023

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PEARL PAVILION	900 SOUTH KIWANIS DRIVE FREEPORT, IL 61032

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S9999	Continued From page 27 all over the top of her right foot, going over intact skin and then the 2 open areas on her right foot (one near the arch of her foot and the other at the top by her first and second digits). R54 said "I know I should use gloves, but I can't feel my fingers with them on." R54 dropped the rolled gauze onto the floor and it rolled about 8 inches from her wheelchair. R54 used a reacher bar to scoot the gauze close enough back toward her to where she could pick it up. R54 placed the rolled gauze back on her table with the other wound supplies. R54 grabbed three abdominal pads from the bedside table and placed them on her abdominal area of her shirt, with the blue line facing out. R54 taped the three abdominal pads together and then wrapped them around her right leg, with the sides of the abdominal pads that had been in contact with her shirt directly over the oil emulsion dressings. R54 grabbed the rolled gauze that had recently been on the floor and wrapped the rolled gauze around the abdominal pads on her right lower leg. R54 grabbed scissors and cut a section of the rolled gauze to tie together in order to secure the gauze to her right leg. After wound care R54 put the supplies back in the bottom drawer. R54 did not perform hand hygiene after wound care. R54's Nursing Progress Note dated 3/1/23 at 3:08 PM, showed, Late Entry: (entered on 3/3/23) Note Text: I talked to this resident about doing her legs. She stated that she can do her own legs. I told her that I could do them. She said you don't do them right anyway. I asked if the way you do your leg is how you want them done. She said yes. I reached out to the Wound Doctor, she stated that the resident will be discharged from the Wound Center because she has refused or don't want to do any of the treatment they have offered for her. I told the doctor that she stated	S9999		

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	IL6003339	A. BUILDING: _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 28	S9999		

that she likes the way that she does her own legs. She told me to get in contact with the MD. I sent him a note and told him about what was going on with the resident and how she has started doing her own legs, because she refuses a lot. The Physician gave the order to let her do her own legs if she prefers. I will monitor the legs for signs or symptoms of infection or edema. Resident told about the order.

R54's Order Summary Report, listing the active orders as of 3/9/23, showed an order on 3/3/23 "Resident to do her own wound dressing because of continuous (refusals). Nurse will monitor the lower legs for signs and symptoms of infection or edema one time a day, every 6 days for wound care. the report showed an active order dated 2/9/23 for right and left leg and right heel: Apply a thin layer of betamethasone valerate 0.1% over the adaptic dressing (a dressing with a specially formulated petrolatum emulsion to help protect the wound while preventing the dressing from adhering to the wound) and apply to the entire open wound from heel up on the right lower leg. Cover with a 4 x 4 gauze, Qwik (an absorbent and wicking dressing) and ABD (abdominal) pad. Secure with (rolled gauze), paper tape and a 6 inch ace wrap three times a day for wound care. The Order Summary Report also showed an order for Ciprofloxacin HCl 500 mg (milligram) tablet twice daily for leg infection until 4/9/23. R54's Unit Nurse Skin Review dated 3/7/23 showed she has open ulcers and cellulitis. R54's Skin/Wound note dated 3/2/23 showed "The resident has a venous ulcer on the right and left leg. Both of the lower legs are macerated (moisture associated skin damage). The right leg venous ulcer measures 12.5 x 44.5 x 0.1 cm (centimeters) with large serous (thin, watery fluid that is produced in response to local

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003339	A. BUILDING: _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 29	S9999		

inflammation) drainage. This wound is a full-thickness wound. The left venous ulcer measures 12.0 x 15.8 x 0.1 cm. This venous ulcer is full thickness with moderate drainage..."

On 3/8/23 at 1:30 PM, an assessment of R54's abilities to perform wound care on her own was requested.

On 3/9/23 at 10:23 AM, V2 (Director of Nursing) said she did not see an assessment in R54's medical record to determine her ability to perform self-wound care. This surveyor's observation of R54 performing wound care to her right leg was described to V2. At 10:30 AM, V2 stated, "Based on the information you just provided, it is obvious that we should be doing her wound care and she should not be doing her own wound care."

4. R1's electronic face sheet printed on 3/9/23 showed R1 has diagnoses including but not limited to chronic respiratory failure, chronic obstructive pulmonary disease, pneumonia, congestive heart failure, acute kidney failure, fluid overload, and hypertension.

R1's facility assessment dated 2/3/23 showed R1 has no cognitive impairment.

On 3/7/23 at 7:53AM, R1 stated, "I go to the hospital quite often, usually for my congestive heart failure. They used to weigh me every day but for some reason they don't anymore. They hardly ever weigh me and the doctors always tell me I need to monitor my weight to see if I'm retaining fluid."

R1's weight record showed for February and March 2023 showed R1 is weighed 3-4 times per month. R1's weight record showed on 2/24/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003339	A. BUILDING: _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL PAVILION	900 SOUTH KIWANIS DRIVE FREEPORT, IL 61032

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S9999	Continued From page 30 R1's weight was 344.8lbs (pounds) and on 3/6/23 R1's weight was 349.8lbs (5 lb. weight gain in 1 month). R1's nursing progress notes dated 2/19/23 showed, "Patient complaining of shortness breath and difficulty catching his breath. Patient oxygen 89% with 4 liters per nasal cannula, desaturating ranging from 84-86%. Not able to titrate levels above 90%. Patient stated that he would like to go to the hospital to be evaluated. Patient note with elevated Blood pressure 129/102 heart rate: 110. Call placed to (local ambulance)...Patient admitted with bilateral pneumonia per (local hospital)." R1's nursing care plan dated 12/18/22 showed, "The resident demonstrates a potential for fluid overload related to: noncompliance. Education provided on risks of fluid overload, patient states, "I do not care about diet or fluid restriction, it makes me happy and I will die happy." Physician notified of non-compliance, assess for signs and symptoms of fluid overload & notify the physician if signs and symptoms of fluid overload are present: adventitious lung sounds, observe, assess & record signs of edema." R1's local hospital discharge records dated 2/24/23 showed, "Weigh yourself daily before breakfast. Notify physician if 3lb weight gain in 24 hours or 5lb weight gain in 1 week." R1's physician's orders showed an order for daily weights was discontinued in November 2022 when resident was sent to the local hospital. R1's daily weight physician's order was not reinstated when he returned back to the facility in November 2022.	S9999		

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	IL6003339	A. BUILDING: _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL PAVILION	900 SOUTH KIWANIS DRIVE FREEPORT, IL 61032

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S9999	Continued From page 31 On 3/9/23 at 9:05AM, V4 (Certified Nursing Assistant) stated, "All residents are weighed per orders and the nurse gives us a list of who needs to be weighed. If the nurse notices a discrepancy then she will have us reweigh them. (R1) is weighed monthly as far as I know. We haven't been asked to weigh him more often. He would even go down and weigh himself if we asked him to." On 3/9/23 at 9:53AM, V2 (Director of Nursing) stated, "Weights should be obtained per physician's orders. Best practice for a resident with congestive heart failure is to weigh them every day to keep an eye on their fluid status and be aware of any concerns with fluid overload." 5. R20's nursing progress notes for 3/4/23 at 5:20 PM document she had complaints of flank pain and shortness of breath. Her vital signs included a blood pressure of 144/91 and pulse oximetry level of 86% on room air. R20's daughter who was present at the time requested R20 be sent to the hospital for evaluation. The notes show R20 was sent out and admitted to the hospital for a pulmonary embolism (blood clot in the lung). R20's progress note of 3/8/23 at 1:51 PM shows she returned from the hospital via stretcher at 12:46 PM, she was alert and oriented x 2. No complaints of pain and her call light was in reach. The nursing note did not include any assessment or vital signs upon her return. The assessments were reviewed for 3/8/23 and show no assessment until 10:06 PM. That assessment showed vital signs taken on 3/4/23 at 10:00 AM, before R20 was sent out to the hospital. No current vital signs are documented in the computer charting program.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003339	A. BUILDING: _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL PAVILION	900 SOUTH KIWANIS DRIVE FREEPORT, IL 61032

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S9999	Continued From page 32	S9999		

On 3/9/23 at 11:58 AM, V29 LPN said R20 just came back from hospital and is on a 72 hour monitor status, so the nurses document her condition and pain level every shift. Vitals are done every shift and are documented in the computer under assessments and vital signs tabs. V29 said when a resident returns from hospital the nurse should do an assessment, get vial signs notify the family and physician of their return. She said when vital signs are posted in the record, they will transfer over to the vital signs tab. V29 said she had not obtained R20's vital signs yet for her shift.

On 3/9/23 at 12:24 PM, V2 said when a resident returns to the facility, they are a re-admit and should follow the same procedures as a new resident. The nurse should do a physical assessment including a set of vital signs. V2 said the manager V15 (Registered Nurse) was on duty and should have either obtained a fresh set of vitals or had an aide get them for her. V2 checked R20's record and said the last set of vital signs she sees are from 3/4/23. V2 said there is no excuse for not having the assessment and vital signs completed.

The facility's 11/2022 policy for admission of a resident shows the purpose of the policy is to facilitate smooth transition into a health care environment and to gather comprehensive information as a basis for planning individualized therapeutic care. Procedure: 9. Conduct head to toe nursing assessment of body systems, parts, and surfaces identifying functional status abilities, needs, or problems. Be sure to measure any areas of redness or skin breakdown on extremities or other skin surfaces. 18. complete admission record, charting, T.P.R

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003339	A. BUILDING: _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL PAVILION	900 SOUTH KIWANIS DRIVE FREEPORT, IL 61032

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S9999	Continued From page 33 (Temperature/Pulse/Respirations), Blood pressure, height and weight. 20. Record in detail on nurses' notes all other pertinent information such as: a. Findings from the assessment-required to meet the residents needs, which can in turn be conveyed to the physician so the admission orders cover all aspects of required treatment. (A) 4 of 5 300.615 f) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information. f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. This regulation was not met as evidenced by: Based on record review and interview, the facility failed to check the Illinois Department of Corrections website and the Illinois State Police website within 24 hours of admission. This applies to 3 of 10 residents (R29, R56, R211) that were reviewed for criminal backgrounds in the sample of 10. The findings include:	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003339	A. BUILDING: _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL PAVILION	900 SOUTH KIWANIS DRIVE FREEPORT, IL 61032

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S9999	Continued From page 34 The computer admission record for R29 documents he was admitted on 1/1/23. The criminal history background check was completed on 12/29/22, and no website checks were completed to determine if R29 was a registered sex offender. The computer admission record for R56 shows she was admitted on 1/21/23, and has no record of sex offender websites being checks in her file. The computer admission record for R211 documents an admission date of 3/4/23 and no record of the facility checking the websites for sex offender status. On 3/9/23 at 11:00 AM, V1 Administrator said when a resident is admitted all of the websites are checked including the national sex offender registry and the Illinois sex offenders. When the check is completed, it is printed out and uploaded into their charts. On 3/9/23 at 2:00 PM, V1 said she had searched through her records and can not locate documentation of the website checks for R29, R56 and R211. She said they should have been completed and on file. The facility's undated policy for Identified Offender states it is the policy of this facility to establish a resident sensitive and resident secure environment. In accordance with the provisions of the Nursing Home Care Act, this facility shall check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal convictions. Identifying Offenders: 1. Check for the resident's name on the Illinois Sex Offender Registration Web site. www.isp.state.il.us 2. Check for the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003339	A. BUILDING: _____ B. WING _____	03/09/2023

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S9999	Continued From page 35 resident's name on the Illinois Department of Corrections sex registrant search page. www.idoc.state.il.us (C) 5 of 5 300.661 Section 300.661 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. This regulation was not met as evidenced by: Based on record review and interview, the facility failed to check the healthcare worker registry after submission of fingerprints, failed to check required websites at the time of hire. This applies to 4 of 10 (V21, V22, V23, V24) records reviewed for healthcare worker background check in the sample of 10. The findings include: On 3/9/23 at 10:30 AM, V20 Assistant Administrator/ Human Resources said she is checking the registry when someone submits an application. Once they are approved for hire, the registry is printed off immediately for their file. In addition, the sex offender and IDOC (Illinois Department of Corrections) websites need to be checked. She said there are 6 websites in total.	S9999		

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	IL6003339	A. BUILDING: _____ B. WING _____	03/09/2023

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PEARL PAVILION	900 SOUTH KIWANIS DRIVE FREEPORT, IL 61032

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S9999	Continued From page 36 V20 said if an applicant has no fingerprints on file, they must be initiated in 10 days. Once the fingerprint is completed a new registry check will need to be run to see if they are eligible for hire. All of these checks need to be completed before hire. The facility provided list of hire dates shows V21 was hired on 12/5/22 and had a fingerprint completed on 12/6/22. The health care worker registry check on file shows no fingerprint date, and it was not re-run after completion of her fingerprints. The file does not have the required sex offender checks. The list of hires shows V22 was hired on 12/8/22 and V23 was hired 10/19/22, both files provided do not have the required website checks completed prior to hire. V23's website checks were completed on 3/7/23 during the survey. The list of hire dates shows V24 started 10/19/22. The website checks provided were completed on 12/16/2021. V20 said she was not sure if V24 had worked in the facility in 2021, and returned. She said if there was a break in her employment, all of the necessary websites and background check should have been completed again. The facility's 1/4/19 abuse prevention program facility policy and prevention documents 1. Pre-Employment Screening of Potential Employees. Prior to a new employee starting a work schedule, this facility will: Check the Illinois Health Care Worker Registry on any individual being hired for prior reports of abuse, neglect or misappropriation of resident property, previous fingerprint check results, and the sex offender Website links on the Registry.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 37 (C)	S9999		