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 _____	C 04/02/2024

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

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S 000	Initial Comments Complaint Investigation 2412539/IL171414	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.610b) 300.610c)2) 300.1210a) 300.1210b)4)5) 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. b) All of the information contained in the policies shall be available to the public, staff and residents, and for review by the Department. c) The written policies shall include, at a minimum the following provisions: 2) Resident care services, including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic services (including	S9999		

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S9999	Continued From page 1 laboratory and x-ray) Section 300.1210 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. Restorative measures shall include, at a minimum, the following procedures: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet;	S9999		

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S9999	Continued From page 2	S9999		

eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.
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 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.

These requirements were not met as evidenced by:

Based on observation, interview and record review the facility failed to provide assistance with ADL's (Activities of Daily Living). This failure resulted in R1 being left on the bed pan unattended leading to feelings of pain, frustration, panic and embarrassment.

This applies to 1 of 3 residents reviewed for assistance with ADL's in a sample of 6 residents.

The findings include:

R1 Face sheet shows his diagnoses to include acute respiratory failure with double lung transplant, protein-calorie malnutrition, pneumonia, and type 2 diabetes mellitus.

R1's 3/18/24 MDS (Minimum Data Set) shows, he is fully cognitively intact, and needs substantial/maximal assistance rolling left and

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S9999	Continued From page 3	S9999		

right.

R1's 3/12/24 POS (Physician Order Sheets) shows Physical and Occupational therapy is to evaluate and treat as indicated 3-5 times a week.

R1's 3/13/24 Care Plan shows he has a self care deficit and is dependent with ADL care. The facility must provide total assistance in all aspects of hygiene/dressing.

R1's 3/21/24 Progress Note, by V10 (Nurse Practitioner) shows R1 was referred to skilled therapy related to a noted functional decline. R1 has a decrease in strength, balance, transfers, mobility, and the ability to perform self-care ADL's. The same progress note shows R1 is alert and oriented to person, place, and time.

On 4/2/24 at 10:00 AM, R1 said, on 3/29/24 at 11:00 AM he was placed on the bed pan, and when he was finished having a bowel movement pressed his call light to be taken off. R1 said, staff kept coming in and shutting off the call light and telling him (R1) they would be right back and never returned. R1 said, the bed pan was starting to hurt his bottom and he was feeling frustrated, R1 said, it was like he didn't matter. R1 said, he finally called 911 because he couldn't take it anymore and was starting to panic. R1 became emotional and started to weep when relaying this event. R1 said, it's embarrassing to have to use a bed pan but to be on it for 3 hours and then have a room full of EMS and staff to take him off caused more embarrassment.

On 4/2/24 at 1:00 PM, V7 CNA said, she was R1's CNA on 3/29/24, the day R1 called 911. V7 said, her normal shift is 10:00 AM to 10:00 PM but she was late that day. V7 said, she put R1 on

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the bed pan, but she couldn't remember what time. V7 said, it was before lunch because she remembers R1 was still on the bed pan when she delivered his lunch tray. V7 said, she didn't take him off the bed pan because she got busy and thought someone else would do it. V7 said, she doesn't know what time he (R1) was taken off the bed pan.

On 4/2/24 at 9:45 AM, V2 DON (Director of Nursing) said, we have video of staff going in R1's room several times, so V2 thinks R1 was put on the bed pan at 1:00 PM and taken off at 2:40 PM. V2 said, she assessed R1's bottom at 2:40 PM when EMS (Emergency Medical Service) arrived. V2 said the staff should answer the call light as soon as possible because the resident may be in distress.

On 4/2/24 at 1:00 PM, V4 CNA said, R1 is alert and oriented. V4 said, staying on the bed pan for longer than 1/2 an hour is too long. V4 said the resident should come off the bed pan and try again later, because staying on the bed pan too long could cause skin break down.

On 4/2/24 at 1:00 PM, V5 CNA said, R1 is alert and oriented. V5 said, staying on the bed pan for longer than 1/2 an hour is too long. V5 said, the resident should come off the bed pan and try again later, because staying on the bed pan too long could cause skin break down.

On 4/2/24 at 10:15 AM, V3 (Wound Nurse) said, a 1/2 hour to 1 hour on the bed pan is too long because it might cause skin breakdown. The CNA should take the resident off the bed pan and the resident should try later to use the bed pan.

A Policy and Procedure for Bed Pan use and for

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S9999	Continued From page 5 assistance with ADL's was requested, however V1 (Administrator) said, they did not have one. (B)	S9999		