STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145045	A. BUILDING _____ B. WING _____	09/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PEARL OF NAPERVILLE, THE	200 MARTIN AVENUE NAPERVILLE, IL 60540

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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to assist residents with bathing, hygiene, grooming, and transfering residents to bed. This applies to 3 of 5 residents (R1, R4, R6) reviewed for activities of daily living in a sample of 17. Findings include: 1). The Face Sheet documents R1 is [AGE] years old and has [DIAGNOSES REDACTED]. The Minimum Data Set (MDS), dated [DATE], documents R1 has cognitive impairment, and requires extensive staff assistance with bed mobility, dressing, personal hygiene, and bathing. R1 also has an indwelling catheter. On 9/8/2020 at 10:50 AM, R1 was awake in bed lying on her back and turned slightly towards her left side. R1 had an indwelling catheter draining cloudy yellow urine. There were brownish red stains noted on R1's bed linen. On 9/8/2020 at 1:10 PM, R1 was lying in the same position. V13 (Certified Nursing Assistant/CNA) was asked when she had provided bathing for R1,stated she washed R1's face and changed the linen. R1 was observed to have a [MEDICAL CONDITION] drainage bag on her left side which was full of green liquid feces. R1's nails had blackish substances underneath. R1's skin was flaking, and there were multiple flakes on her linen. When V13 turned R1 to the side, there was an open wound on R1's buttocks, and large brownish red stains on the draw sheet underneath R1. Upon lifting the draw sheet, the fitted sheet had large brown stains. V13 stated she did not change the fitted sheet. She just placed a clean draw sheet on top. R1's indwelling catheter had lots of brown and red crusting from entry point to approximately 4 inches down. V13 covered R1 back up, and left without cleaning her. On 9/8/2020 at 2:04 PM, V7 (Nurse) and V5 (CNA) performed ADL (Activities of Daily Living) care for R1. V5 took a disposable wipe and wiped R1's buttocks. The employees did not cleanse R1's catheter tubing, labia, or perineum. The employees did not empty the [MEDICAL CONDITION] bag. They then replaced the linen and covered R1 with a clean sheet, stating care is complete. The policy for catheter care reads: using disposable wipes cleanse female labia with single downward, cleansing [MEDICAL CONDITION] using a different side of the wipe for each cleansing stroke for each side of the labia and the urethra meatus. 2). The Face Sheet documents R4 is [AGE] years old and has [DIAGNOSES REDACTED]. The Minimum Data Set (MDS), dated [DATE], documents R4 has cognitive impairment and requires extensive staff assistance with bed mobility and transfers. The MDS also documents R4 has limited range of motion in one upper extremity and both lower extremities. The Care Plan reads: Self-care deficit as evidenced by need for staff assistance related to decreased standing balance, left sided weakness, left hemi, impaired cognition. Will receive assistance necessary to meet ADL needs. On 9/8/2020 at 11:02 AM, R4 was sitting in the reclining chair in her room. At 2:00 PM, R4 was still in the chair in the same position. There were food crumbs on R4's clothing. R1's nails contained black and brown substances underneath. R4 stated she has been wanting to get out of the chair because her legs hurt. V9 (CNA) and V13 (CNA) placed R4 to bed and checked her for incontinence. V9 stated the last time R4 was checked, changed, and reposition was around 11:00 AM when she was placed into the chair. V9 stated R4 spilled her lunch on herself. V13 stated, Oh her nails are dirty. 3). On 9/8/2020 at 12:00 PM, R6 was sitting his wheelchair near the nursing station. R6's beard was unkempt and needed shaving. On 9/9/2020 at 9:20 AM, R6 was sitting in his wheelchair near the nursing station. R6's face was dirty and there was yellow crusting in his right eye. R6's beard was again unkempt. R6 stated he wanted to be shaved. The policy for ADLs read: Procedure: A program of activities of daily living is provided to prevent disability and return or maintain residents at their maximal level of functioning based on their diagnosis. 1. The ability of each resident to meet the demands of daily living is determined by a Licensed Nurse. 2. A program of assistance and instructions in ADL skills is care planned and implemented. Hygiene Resident self-image is maintained Showers or baths are scheduled, and assistance is provided when required
F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide restorative programming. The facility also failed to apply R4's hand splint as per plan of care. This applies to 4 of 5 residents (R1, R2, R4, R5) reviewed for restorative programming and adaptive equipment in a sample of 17. Findings include: 1). The Face Sheet documents R4 is [AGE] years old and has [DIAGNOSES REDACTED]. The Minimum Data Set (MDS), dated [DATE], documents R4 has cognitive impairment and requires extensive staff assistance with bed mobility and transfers. The MDS also documents R4 has limited range of motion in one upper extremity and both lower extremities. The Care Plan for splint/brace documents R4 has a palm splint for her left had due to joint stiffness, immobility, contractures, impaired functional mobility, [MEDICAL CONDITION] related cerebral Infarction, muscle weakness, and chronic pain. Goal- will apply and remove splint with staff assistance 6-7 days per week. Interventions include: Assure left extremity is in proper body alignment; and provide hygiene to left hands before applying splint/brace. The Care Plan for range of motion (ROM) documents passive range of motion BUE (Bilateral upper extremities)/RLE (right lower extremity) related to joint stiffness, immobility, contractures, impaired functional mobility, [MEDICAL CONDITION] related to cerebral infarction, muscles weakness, pathological fracture, disease of bone density and structure, chronic pain, and left tibia closed fracture. Goal-Resident will receive 3 sets of 5 reps of PROM (Passive Range Of Motion) to BUEs/RLE, 6-7 days per week. On 9/8/2020 at 11:02 AM, R4 was sitting in a reclining chair in her room. R4's left hand/wrist was contracted and in a dependent position. R4 was unable to extend her fingers when requested. There was no supportive device on R4's wrist/hand. At 2:00 PM, R4 was still sitting in the same position with no splint to her wrist. R4 was stating her legs hurt from sitting so long. On 9/9/2020 at 10:20 AM, V3 (Restorative Nurse) stated R4 is on PROM to all extremities 6 days a week. R4 is to have a palm protector to her left hand for 4 hours in the morning. PROM and palm protector application is to be done by the CNAs (Certified Nursing Assistants). V3 stated she was in the process of explaining to the CNAs how to perform range of motion exercises before the pandemic. V3 stated R4 is to receive abduction, adduction, flexion and extension exercises to all extremities for 15 minutes at a time. V3 stated however, she has not shown the CNAs how to perform the exercises yet. V3 stated, prior to applying the splint CNAs are to soak R4's hand in water. On 9/9/2020 at 10:30 AM, V6 (R4's assigned CNA) stated there is no restorative program. V6 stated she does not perform any exercises for R4 because she's always in pain. V6 was also asked if there's any requirements prior to applying R4's splint, to which V6 replied no, we just put it on her hand. On 9/15/2020 at 1:00 PM, R4 was awake in bed. R4 did not have the palm protector on her left hand. V5 (CNA) was asked why doesn't R4 have the palm protector, to which she replied, R4 removes it herself. The palm protector was noted on the nightstand that was against the wall across from R4's bed. V5 was asked how the device got across the room, then R4 stated V5 never applied the device to her hand. 2). The Face Sheet documents R1 is [AGE] years old and has [DIAGNOSES REDACTED]. R1 requires extensive staff assistance for bed

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145045	A. BUILDING _____ B. WING _____	09/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PEARL OF NAPERVILLE, THE	200 MARTIN AVENUE NAPERVILLE, IL 60540

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 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) mobility, transfers, and dressing. R1 has limitation in range of motion to both lower extremities. R1's joint mobility assessment dated [DATE] shows R1 has moderate/severe limitations in her upper extremities and severe (0%- 25%) ROM in her lower extremities. Review of R1's joint mobility assessments shows the previous assessment was done on 1/7/2020 which also showed severe limitations. There were no other assessments from 01/2020 - 08/2020 The Care Plan documents R1 requires passive range of motion (PROM) to BUE (bilateral upper extremities) and BLE (bilateral lower extremities) related to contractures. Interventions- will be assisted with performing PROM to all extremities X 10 reps all joints 6 days a week as tolerated (date initiated 8/24/2020). On 9/8/2020 at 10:50 AM, R1 was awake in bed. R1 was lying on her back and slightly turned towards her left side. R1's wrists were both contracted with hand splints. R1's right leg was contracted at approximately 90 degrees, and the right knee was pressing into her left thigh. R1 could not lift her leg on command. There was no assistive device (s.a. pillow) between R1's legs to relieve pressure. At 1:10 PM, and 2:04 PM, R1 remained in the same position. On 9/9/2020 at 9:46 AM, R1 was again lying on her back with the right leg contracted and cross the left leg. V5 (Certified Nursing Assistant/CNA) was R1's assigned caregiver. When asked if V5 perform exercises/ROM for R1, V5 replied No, we do not have restorative programs anymore. The new company cut it out. On 9/9/2020 at 10:20 AM, V3 (Restorative Nurse/Falls Coordinator) stated R1 is on restorative programming for PROM abduction, adduction, flexion and extension to all extremities 3). The Face Sheet documents R5 is [AGE] years old and has [DIAGNOSES REDACTED]. The Care Plan documents AROM (Active Range Of Motion) program: Resident requires active range of motion to BUEs/LLE (left lower extremity) related to Impaired physical mobility and balance secondary to [MEDICAL CONDITION], proximal tibial fracture, fracture around internal prosthetic right knee joint, immobilizer in place, [MEDICAL CONDITION] and other co-morbidities. Interventions- Discuss restorative AROM program with resident/responsible party. Demonstrate AROM program as needed. Provide staff assist with AROM at level resident requires, (set up, physical assistance, cueing, encouragement, oversight). On 9/8/2020 at 11:05AM, R5 had a brace to her right leg. R5 stated she is supposed to be in restorative programming which she has not received. R5 stated there were 2 restorative CNAs, but the facility sent them back to work the units. On 9/9/2020 at 10:20 AM, V3 (Restorative Nurse) stated R5 is supposed to be on restorative for active range of motion to all extremities except her right leg. The exercises are to be completed by the assigned CNA. V6 (CNA) was interviewed and stated she does not provide restorative exercises for R5. 4). The Face Sheet documents R2 is [AGE] years old and has [DIAGNOSES REDACTED]. The Care Plan documents: Walking program- Resident requires restorative walking program due to his difficulty in walking, fall risk, weakness, acquired absence of right [MEDICAL CONDITIONS], rhabdomyolysis, and other co-morbidities. Goal- will safely ambulate 60 feet using rolling walker, gait belt, right prosthesis, left orthotic shoe, with 1-2 staff assist, 6-7 days per week. Intervention- 2 staff assist for getting up from wheelchair and due to occasional lightheadedness. Resident ambulate using rolling walker, x1 staff contact guard when walking using gait belt and another staff to follow closely with wheelchair. On 9/8/2020 at 10:56 AM, R2 was awake in bed. R2 has a right [MEDICAL CONDITION]. R2 stated staff are supposed to ambulate with him daily, and this has not occurred. On 9/9/2020 at 10:20 AM, when interviewed, V3 stated staff are supposed to place R2 in the wheelchair, then ambulate with him in the hall to 60 ft 6-7 days a week. However, this has not occurred. V3 was asked to provide the restorative tasks showing the exact exercises performed in accordance with plan of care, including minutes for each task for R1, R2, R4 and R5 for Jul, Aug and Sep 2020. V3 stated she could not find the documentation. The facility however, provided the documentation for the residents for the month of Sep/2020. There were multiple inconsistencies with tasks being documented as completed when staff and residents interviewed stated the tasks are not being done. There were also some dates with no documentation and some with N/A in the boxes for activities performed. The facility did not provide the tasks for Jul and Aug/2020 for any of the 4 residents. The policy for Restorative Nursing Program reads: It is the facility's policy to assist each resident to attain and or maintain their individual highest most practicable functional level of independence and well-being, in accordance to State and Federal Regulations. 3). The facility restorative nursing program will include but not limited to the following programs -Hygiene- bathing, dressing, grooming and oral care -Mobility- transfer and ambulation, including walking, prosthetic and or splint application with or without active and or passive range of motion, bed mobility -Elimination- toileting, bowel and bladder 4). The above programs will be documented on the facility designated restorative care forms/tools in the resident's electronic health record.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to follow the plan of care when transferring a resident who sustained a fall in the facility. This applies to 1 of 3 residents (R8) reviewed for falls/hazards in a sample of 17. The Face Sheet documents R8 is [AGE] years old and has [DIAGNOSES REDACTED]. The Minimum Data Set (MDS), dated [DATE], shows R8 has no cognitive impairment. The MDS documents R8 requires staff assistance with toileting, transfers, and ambulation. R8 is not steady, and only able to stabilize with staff assistance with moving on and off toilet, and surface-to-surface transfers. R8 has impairment to both lower extremities and is wheelchair bound. The progress notes for R8 reads: 5/23/2020 at 3:21 PM, the CNA (Certified Nursing Assistant) was in training and assisting R8 with toileting when R8 missed the rail and fell . Resident complained of pain on her bottom. The Fall Risk Assessment 5/23/2020 documents R8 is high risk for falls. The Care Plan reads: The resident has had an actual fall with no injury, transferring to toilet due to left sided [MEDICAL CONDITION]/[MEDICAL CONDITION] follow cerebral infarction, decreased balance, and unsteady gait. Date Initiated: 05/26/2020 (3 days after the fall). Intervention- Continue interventions on the at-risk plan. Encourage resident to transfer and change positions slowly. Reeducated staffs on fall interventions and plan of care. Reinforced the use of gait belt during transfers and ambulation related to the fall on 5/23/2020. On 9/15/2020 at 1:00 PM, V3 (Restorative Nurse) was asked to provide the fall incident for R8, in which V3 stated she could not find it. On 9/15/2020 at 1:45 PM, R8's call light was activated. R8 was sitting in the wheelchair in her room. R8 stated she wanted to go to the bathroom. R8 stated when she fell on [DATE], the CNA was pulling her pants up as she held onto the railing. R8 stated she had a stroke and has weakness on her left side and can only hold on with her right hand. R8 stated she informed the CNA she was losing her grip, but the employee continued tugging at her pants. R8 stated she then lost her grip and fell , injuring herself on the floor. R8 stated the CNA did not use a gait belt and employees never use a gait belt with her. While the surveyor was in R8's room, V25 (Nurse) entered. V25 took R8 to the bathroom and assisted with transfer to the toilet. V25 did not use a gait belt. When R8 was done, V3 (Restorative Nurse) came and assisted R8 back to the wheelchair. As R8 came to a standing position, V3 stated she does not have a gait belt. V3 assisted R8 with stepping towards the wheelchair and seating without the use of a gait belt. On 9/15/2020 at 2:25 PM, V3 stated the policy for transferring one person is to use a gait belt. The policy titled Proper Transfer Techniques How to assist residents with walking- 2 Always use a gait belt if recommended by a doctor or therapist.