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 _____	**08/14/2020**

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 interview and record review, the facility failed to provide incontinence care and assistance for a resident needing moderate to extensive assistance with ADLs (Activities of Daily Living). This applies to 1 of 7 residents (R1) reviewed for ADLs in the sample of 7. The findings include: R1's [DIAGNOSES REDACTED]. On 8/11/2020 at 10:00 A.M., R1 was lying in bed. R1 was awake, alert and oriented times 3, pleasant and was able to verbalized needs. R1 had an undershirt on, adult disposable brief, no pants, and a top sheet on him. R1 stated that was his preferred outfit when in bed. R1 had verbalized his frustration and anger towards V5, CNA (Certified Nurse Assistant/ From an Agency staffing). R1 stated that on 8/8/2020 around 6:45 P.M., he called for assistance to be cleaned for incontinence care due to his bowel movement. R1 also added that he had diarrhea at that time. R1 also stated that V5 came to provide incontinence care to him. R1 also added that V5 took towels, turned R1 to side and started to wipe R1's buttocks/scrotal and groin areas. R1 added that V5 was very rough wiping him and he felt like her (V5) thumb was stuck into my anus. I told her to stop, you're hurting me, you are too rough, and also you are using towels instead of wipes. She (V5) continued to roughly wipe me despite that I told her to stop, so I yelled at her and said GET OUT. R1 further added that V5 did not finish cleaning him, left R1 halfway down naked, left R1's room and shut the door. R1 added that he turned on his call light and waited for someone to help assist him with his incontinence care. R1 also added that he waited for almost 2 hours for someone to answer his call light, but no one came to answer and attend to his incontinent needs. R1 further added that he then decided to call the police department since he had been waiting to be cleaned and no one was coming. On 8/12/2020 at 11:00 A.M., V3 (Registered Nurse) stated that R1 never complained of abuse or rough handling except what happened to him on 8/8/2020 toward V5. V3 also added that (R1) is a reasonable person, but is very particular with care, demand request but not over the top, I have a good rapport with him. (R1) told me that (V5) was very rough when (V5) wiped (R1) perineal area using towels. (R1) also stated it felt like (V5) had her thumb stuck into my anus. I'm not sure if it was abuse or willful on part of (V5), however, it sounded like rough handling, using a towel and cleaning sensitive area of (R1). It is hard to say V5 intentionally hurt (R1), but (R1) he told me he waited for almost 2 hours for his unanswered call light. (R1) stated he waited for almost 2 hours and no staff came in to help clean him, so he said he decided to call the police department. On 8/12/2020 at 2:15 P.M. V4 (Nurse for R1 on 8/8/2020 from 7:00 A.M.-7:00 P.M.) stated that V5 informed her that R1 does not want V5 to clean him up and that R1 yelled at V5. V4 added that this had happened around 6:45 P.M. on 8/8/2020. V4 also stated that she told V5 to get another staff to help V5 and continue cleaning R1. V4 also added that she informed V5 that if R1 remained to yell then to call V4 and she will assist V5 to provide R1's incontinence care. V4 stated further that she saw R1's call light was on at 6:55 P.M. on 8/8/2020, with R1's door closed. V4 also stated that she did not check why R1's light was on but assumed that staff were providing R1 care since the door was closed. V4 added that she left her shift at 7:10 P.M. and did not inform V9 (Registered Nurse) regarding R1 yelling at V5. V4 also added that she assumed it was all taken care of and that R1 was provided care by V5. On 8/12/2020 at 3:45 P.M., V9 stated that she was surprised when V11 (Police Officer) showed up at the facility at around 8:45 P.M. on 8/8/2020. V9 added that she followed V11 to R1's room. V9 also stated that R1 was wearing an undershirt, no adult brief incontinence pad but has a top sheet on him but partly exposed his left leg (R1 is a right leg [MEDICAL CONDITION]). After V11 was done with interviewing R1, V9 went to R1's room. V9 asked R1 what happened. V9 stated that R1 had complained that V5 was very rough earlier while providing incontinence care to him. V9 also added that he felt uncomfortable because he felt that V5 had stuck her thumb into his anus so R1 decided to yell at V5 and asked for the nurse. V9 also added that there was no staff that came in when R1 turned on his call light for almost 2 hours, left unclean so R1 decided to call the police department. V9 also added that she immediately assessed R1 for any injury and found none. V9 also added that she immediately called V2 (Director of Nursing) and V2 then called V1 at once. V9 also added that V1 came in that night to investigate R1's concern. V9 also added that she had asked V7 and V8 (both CNAs- Certified Nurse Assistant) to clean R1 and put on adult brief incontinent pad. As V9 added, that was the baseline outfit of R1 when in bed. V9 also stated that R1 needed moderate to extensive assistance with his ADLs. On 8/12/2020 at 4:00 P.M., V7 added that on 8/8/2020 at around 8:45 P.M., V11 came in to facility because R1 called 911. V7 stated that she was not paying attention to R1's call light since she was working on the opposite hallway of R1's room V7 added that both V8 and her had cleaned R1 around 10:00 P.M. when V11 was done with interview and V9 was done checking R1 for injury. V7 also stated that R1's rectal area, anus, scrotum was smeared with bowel movement when they both (V8 and her) proceeded to clean R1. On 8/13/2020 at 3:58 P.M., V8 stated that she did not pay attention to R1's call light because she was with V7 as an orientee. V8 also added that both V7 and her cleaned R1 around 10:00 P.M. V8 also added that both V7 and her proceeded to clean R1 and that R1 was smeared with bowel movement on his scrotum, groins, rectum and anus. The police report dated 8/8/2020 showed that R1 called 911 on the night of 8/8/2020 because there was no staff that was answering R1's call light for around 2 hours to attend to his incontinence care.

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.