STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145234	A. BUILDING _____ B. WING _____	C 09/02/2016

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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint investigation 1614951/IL 88115	F 000		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a cognitively impaired resident with a history of falls was supervised and safely transferred. The facility failed to ensure the safety of residents by making sure medications were packaged and secured. This applies to 5 of 14 residents (R2, R11, R12, R13, R14) reviewed for safety and supervision in the sample of 14. The findings include: 1. The MDS (Minimum Data Set) of May 25, 2016 shows R2 is cognitively impaired and requires extensive staff assistance with bed mobility, transfers, dressing, and hygiene. This MDS shows R2 ' s balance is unsteady with standing and moving from a seated to standing position. The May 25, 2016 MDS show R2 has a history of falls. R2 ' s September 22, 2015 care plan shows R2 has short-term memory deficits, and " her safety awareness skills and judgment is impaired. " R2 ' s Potential for Injury care plan dated December	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145234	A. BUILDING _____ B. WING _____	C 09/02/2016

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) COMPLETION DATE
F 323	Continued From page 1	F 323		

22, 2015 shows " potential for injury from falls related to cognitive deficit, not remembering that she needs to ask for assistance prior to transfers ... " This care plan shows R2 fell on May 18, May 31, June 3, June18, June 19, July 2, July 20, and August 25 (8 times in 3 months). This care plan shows R2 should have a bed alarm and chair alarm.

On September 1, 2016 at 4:32 AM, R2 was sitting in a hard-back facility chair in the lounge in front of the nurse station. R2 was leaning forward and then moving backward in the chair. R2 ' s wheelchair was approximately 4-5 feet away from her with a chair alarm in place, not connected to R2. R2 was not in view of facility staff, who were in resident rooms providing care.

On September 1, 2016 at 4:45AM, E8 CNA (Certified Nurse Assistant) was in the bathroom with R2. R2 was attempting to stand without assistance, and E8 told R2 to wait for help, she could not stand by herself. E8 said she transferred R2 from the facility chair to her wheelchair, and R2 did not have the chair alarm on, and they don ' t put the alarm on her when she is in the facility chair because she can ' t get out.

At 5:01 AM, R2 was sitting in the lounge in her wheelchair, out of view of the staff that was in resident rooms. R2 was asking R12 to help her get into the chair (facility chair). R12 was attempting to help R2 stand, and R2 ' s wheelchair was unlocked and sliding backwards. R2 ' s bottom was off the edge of chair seat, and R2 ' s chair was rolling as she attempted to stand. This surveyor asked R12 to wait for help and to not help R2 to the chair. This surveyor then alerted the nurse (E7 - Licensed Practical Nurse-LPN) who was at the end of the hallway (out of view of the lounge). No CNAs were visible

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145234	A. BUILDING _____ B. WING _____	C 09/02/2016

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) COMPLETION DATE
F 323	Continued From page 2	F 323		

to ask for help. R7 approached R2 and told R12 that he could not assist R2 into the chair.
At 5:06 AM, E7 said R12 is confused, and not capable of transferring R2. E7 said " that ' s what he [R12] does " and he also pushes residents into the wrong room.
At 4:30 AM, E7 said R2 is a high risk for falls, and had attempted twice to get up " last night " . E7 said R2 attempts to get up all the time, and falls have increased on the second floor. At 12:19PM, E4 (LPN) said R2 is high risk for falls, and is more likely to fall at night. E4 said R12 is not capable of helping other residents transfer. E4 said they try to have someone supervise the lounge while residents are in it. E4 said R2 should have a safety alarm on at all times, and when she is in a chair, her wheelchair, or bed. At 12:30PM, E3 (Charge Nurse) said R2 is a " very " high risk for falls, and at 2:00PM, E2 DON (Director of Nursing) said R12 should not be transferring residents.
The facility March 2015 Supervision and Safety policy states " Resident supervision is a core component to resident safety ...socialization between residents will be encouraged daily in " public " areas for increased supervision ... "
2. On September 1, 2016 at 4:20 AM, R2 and R12 were in the second floor lounge across from the nurse station. R12 was walking around and R2 was sitting in a facility chair. E7 (LPN) was sitting behind the nurse station. A medication cart was to the side of the nurse station with 3 individual medicine cups with one unpackaged pill in each cup. The top of the medication cart also had 4 open, unpackaged fentanyl (high-dose scheduled II narcotic) patches. When asked, what the medications were, E7 left the nurse station and pointed to the individual cups and said the first medication was tramadol (pain reliever),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145234	A. BUILDING _____ B. WING _____	C 09/02/2016

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) COMPLETION DATE
F 323	Continued From page 3	F 323		

the second Ativan (anti-anxiety), and the third norco (class II pain medication). E7 identified the fentanyl patches as two 12mcg/hr (microgram per hour), one 37.5 mcg/hr, and one 25 mcg/hour. E7 said yes, she was aware the medications were unpackaged, unlabeled, and out in the open on the medication cart. E7 said she does not always do that.

At 4:52AM E7 was down the hall in a resident room. E7 ' s medication cart was in the hallway, out of E7 ' s sight, with three unpackaged, open nitroglycerin (heart medication) patches sitting on top. E7 said two of the patches were 0.2mg/hr (milligrams per hour), and one patch was 0.4mg/hr.

At 5:06 AM, E7 was in the lounge assisting R2 who was being transferred by R12. E7 ' s medication cart was at the end of the 213-222 hall, out of eyesight of the lounge. No other staff were present. E7 then walked into a linen closet (out of view of her cart). E7 ' s medication cart had an unpackaged blue pill sitting in a medication cup and the same unpackaged nitroglycerin patches. E7 walked up to the cart and identified the pill as synthroid (thyroid medication).

At 4:25 AM, E12 (Registered Nurse-RN) said medications should never be left open on top of a medication cart. E12 said if medications are opened, they should be labeled with the resident name, and medication. At 6:30 AM, E7 said R12 is confused, wanders, and needs a lot of redirection. At 12:30PM, E3 (Charge Nurse) said medications should not be left open, on top of a medication cart. E3 said medications should not be prepared in advance, but should be done one resident at a time, and administered after they are opened. E3 said opened medications should be labeled with a resident name, and the name of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145234	A. BUILDING _____ B. WING _____	C 09/02/2016

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) COMPLETION DATE
F 323	Continued From page 4 the medication. At 2:00PM, E2 (DON) said medications should be locked in drawers, and open medications should not be left on the top of medication carts especially narcotic medications On September 1, 2016, the facility provided a list identifying R11, R12, R13, and R14 as residents who are confused, and wandering can propel throughout the unit. The facility's March 2015 Supervision and Safety policy states " our facility-oriented approach to safety addresses risks for groups of residents such as wanderers, behaviors, aggressiveness, confusion, etc ...staff to decrease safety risk factors as much as possible. " The undated facility " Medication Administration Policy " states " mediations may not be pre-poured,..only prepare and administer medications for one resident at a time ...class II medications are under double lock. If Class II medication and/or b) handle, carry, and/or use the controlled medication key.. "	F 323		