

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145473	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2024
NAME OF PROVIDER OR SUPPLIER Pearl of Orchard Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 2330 West Galena Boulevard Aurora, IL 60506	

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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490</p> <p>Based on interview and record review the facility failed to ensure a care plan conference that included the resident, resident representative and interdisciplinary team was performed to develop a comprehensive care plan within 7 days after completion of the comprehensive assessment for 2 of 3 residents (R1 and R3) reviewed for comprehensive care plans in the sample of 4.</p> <p>The findings include:</p> <p>1. R1's Face Sheet shows that she admitted to the facility on [DATE] with the diagnoses of cellulitis of the left lower limb, atrial fibrillation, resistance to vancomycin, methicillin resistant staphylococcus aureus infection, end stage renal disease, diabetes mellitus, morbid obesity, anemia, dependence on renal dialysis, weakness, pressure ulcer of left hip-stage 4, pressure ulcer sacral, unsteadiness of feet, chronic osteomyelitis, acute kidney failure, thrombocytopenia, venous insufficiency and hypothyroidism.</p> <p>R1's Comprehensive Assessment was completed on 5/21/24.</p> <p>R1's Nursing Notes show that she was discharged to the hospital on 5/31/24.</p> <p>R1's Electronic Medical Record (EMR) does not document that R1 had a Care Plan Meeting nor had a Care Plan Meeting scheduled throughout her stay.</p> <p>2. R3's Face Sheet shows that he admitted to the facility on [DATE] with a diagnoses of osteomyelitis of right ankle and foot, diabetes mellitus, anemia, hypertension, gastro-esophageal reflux disease, alcohol abuse, obesity, unsteady feet, hyperlipidemia, constipation, displaced fracture of right great toe and displaced fracture of proximal phalanx or right lesser toe(s).</p> <p>R3's Comprehensive Assessment was completed on 6/30/24.</p> <p>R3's EMR does not document that R3 had a Care Plan Meeting at any time during his stay.</p> <p>On 7/26/24 at 3:15 PM, R3 said that he has never been invited to or had a care plan meeting since his admission. R3 said that he thinks that one is a good idea because he has concerns about what is going to happen to him after his six weeks of antibiotics are complete and he has some questions about varies diet types that the facility offers.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/26/24 at 3:27 PM, V10 (Social Service Director) said that setting up care plan meetings is her responsibility. V10 said that care plan meetings should be set up upon admission and quarterly after that. V10 said that staff present during the meetings should be the director of rehab, herself, the floor nurse, and any other relevant departments. V10 said that the dietary department would come if the resident was having dietary concerns. V10 said that the meetings would not have a CNA present or physician/ nurse practitioner. V10 said that if a meeting is set up, she would let the resident, family and staff know when it will be and document it in the resident's medical record. V10 said that after the meeting takes place, it will be documented in the resident's medical record. V10 said that the purpose of a care plan meeting is to go over the resident's care and treatments and discuss discharge planning.</p> <p>The facility's Care Plan Conference Policy revised on 9/16/23 shows, The Care Plan Coordinator or designee will notify the resident and responsible party of the initial and quarterly care plan conferences. The residents responsible party will be notified in writing of the conference and the letter maintained in the resident's medical record. The initial care plan is held approximately 14 days after admission .</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident who needs extensive assistance getting to the toilet was brought to the toilet in a timely manner for 1 of 4 residents (R2) reviewed for activities of daily living (ADLs) in the sample of 4.</p> <p>The findings include:</p> <p>R2's Face Sheet shows she admitted to the facility on [DATE]. R2's Physical Therapy evaluation dated 7/25/24 shows that she needs substantial/maximal assistance for transfers.</p> <p>On 7/26/24 at 10:01 AM, V3 (Certified Nursing Assistant/CNA) responded to R2's call light that was going off. R2 asked to get up to go to the bathroom. V3 told R2 that she could not get her up until she was seen by therapy. At 10:05 AM, R2 put her call light back on and was heard from the hallway yelling for help. R2 said that she put her call light on earlier because she had to go to the bathroom and have a bowel movement, but the CNA told her that she could not bring her until after she sees physical therapy. R2 stated, Please help me. R2 said that she has been urinating in her brief since they will not get her out of bed. R2's call light remained on until 10:39 AM when V13 (CNA) entered the room and turned off the call light. V13 exited the room without getting R2 up. V13 said that R2 told her that she wants to get up, but they cannot get her up until therapy evaluates her. At 11:01 AM, V3 and V4 (CNA) entered R2's room. R2 stated, I think I pooped, I can smell it. V3 removed R2's incontinence brief and R2 did have a bowel movement present. R2 said that she is sometimes incontinent of urine, but she has always been continent of stool but couldn't hold it any longer.</p> <p>On 7/26/24 at 1:09 PM, V2 (Director of Nursing) said call lights should be answered in a timely manner. V2 said that if a resident wants to get out of bed and the staff do not know their transfer status, they should look at the (plan of care) in the computer or ask the nurse how they transfer. V2 said that they do not have to see therapy before getting up. V2 said that the nurse can assess their transfer status upon admission or see if their admission paperwork shows their transfer status. V2 said that residents should get the care that they need when they ask for it.</p> <p>R2's (plan of care) shows that R2 transfers with one staff member using a walker and gait belt.</p> <p>The facility's Activities of Daily Living Policy dated 1/1/21 shows, Facility ensures that residents receive ADL assistance and maintains resident's comfort, safety, and dignity. The goal is to maximize the residents and staff safety, confidence, independence and ability to handle everyday activities Residents will be up out of bed, dressed as per the resident's choice</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490</p> <p>Based on observation, interview, and record review that facility failed to ensure pressure ulcer treatment interventions were in place for 2 of 3 residents (R1 and R2) reviewed for pressure ulcers in the sample of 4.</p> <p>The findings include:</p> <p>1. The facility provided Wound Report printed on 7/26/24 shows that R2 has a stage 3 sacral pressure wound measuring 1 centimeter (cm) x 1.5 cm x 0.4 cm.</p> <p>On 7/26/24 at 11:01 AM, V3 and V4 (Certified Nursing Assistants/CNAs) provided incontinence care to R2. R2 had an open wound on her sacrum. Every time V3 wiped R2's buttocks, she said, Ouch. There was no dressing on R2's sacrum or in her incontinence brief that was taken off.</p> <p>On 7/26/24 at 12:21 PM, V11 (Wound Registered Nurse) said that she just did R2's dressing change about 5 minutes ago. V11 said that R2 did not have a dressing in place when she went and did the dressing change. V11 said that R2 has a stage 3 pressure wound on her sacrum that has orders for a dressing. V11 said that if a CNA notices that a wound does not have a dressing on it, they should notify her so she can clean and apply a new one. V11 said that she was not notified that R2 did not have a dressing in place.</p> <p>R2's Treatment Administration Record shows that she has an order for: Wound Care for sacrum: Cleanse with normal saline or wound cleanser; Apply collagen, calcium alginate, then foam; 3 x weekly and as needed.</p> <p>The facility's Wound Prevention and Healing Policy shows, Nurse/therapist will provide wound care per physician orders and continue to implement and evaluate the plan of care</p> <p>2. R1's Wound Care Notes from the local hospital dated 5/10/24 shows she has a wound vac on her left lateral hip and left upper lateral leg</p> <p>R1's Face Sheet shows that she admitted to the facility on [DATE] with the diagnoses of cellulitis of the left lower limb, resistance to vancomycin, methicillin resistant staphylococcus aureus infection, end stage renal disease, diabetes mellitus, morbid obesity, anemia, dependence on renal dialysis, pressure ulcer of left hip-stage 4, pressure ulcer sacral, pressure ulcer of other site-stage 4, chronic osteomyelitis and venous insufficiency.</p> <p>R1's Wound Assessment Report dated 5/18/24 shows that R1 had a stage 4 pressure ulcer on her left lower back of leg measuring 2.5 cm x 1.5 cm x 1 cm. R1's Wound Assessment Report dated 5/18/24 shows that R1 had a stage 4 pressure ulcer on her left trochanter (hip) measuring 5.5 cm x 6 cm.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's May Treatment Administration Record (TAR) shows an order with a start date of 5/21/24 for: Cleanse with Dakin's, apply skin prep to peri-wound, apply NPWT (Negative Pressure Wound Therapy) to left hip at 125 mm hg pressure, use foam, change 2 x weekly as needed for wound care if wound vac is not present cleanser with Dakin's, apply Santyl, calcium alginate, foam. No previous wound orders were on R1's TAR for her left hip pressure wound.</p> <p>R1's May TAR shows an order with a start date of 5/23/24 for: Cleanse with Dakin's, apply skin prep to peri-wound, apply NPWT (Negative Pressure Wound Therapy) to left lower leg at 125 mm hg pressure, Use foam, change 2 x weekly as needed one time a day every Monday, Thursday for wound care if wound vac is not present cleanser with Dakin's, apply Santyl, calcium alginate, foam. No previous wound orders were on R1's TAR for her left lower leg.</p> <p>R1's May Medication Administration Record (MAR) does not document any orders for her left hip or left lower back of leg wounds.</p> <p>R1's Skin/Wound Note dated 5/21/24 shows, Treatments (wound vac on sacrum [per wound Nurse-she meant left hip] initiated), order one for left knee</p> <p>R1's Skin/Wound Note dated 5/23/24 shows, Treatments (wound vacs placed) .</p> <p>On 7/26/24 at 12:21 PM, V11 (Wound Care Registered Nurse) said that R1 came to the facility with multiple wounds. V11 said that she had a wound vac on her left hip and left knee area. R1 said that she initially ordered a wound vac for R1's hip but did not know that her knee needed one as well. R1 said that when she applied the hip wound vac, she noticed that she needed another one for her knee, so she ordered that one and placed it when it came in. V11 said that she was not aware that R1 needed wound vacs until she admitted . V11 said that admissions get their paperwork and would know their needs, but they do not communicate to her what the needs are. V11 said that usually the wound vacs are delivered in 1-2 days. V11 said that in the meantime, dressings should be ordered for the wounds and documented on the TAR. At 2:02 PM, V11 said that wound vacs are very important because they create negative pressure that promotes oxygenation and better blood flow and removes exudate from the wound. V11 reviewed R1's May TAR and MAR and verified that she did not see any wound orders for R1's left hip and left leg until the ones that she put in on 5/21/24 for R1's hip and 5/23/24 for R1's knee but there should have been orders placed.</p>		