

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 02/11/2025
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 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** 45303</p> <p>Based on observation, interview, and record review, the facility failed to provide timely incontinence care to a resident. This applies to 1 of 3 residents (R2) reviewed for timely incontinence care in the sample of 6.</p> <p>The findings include:</p> <p>R2's EMR (Electronic Medical Record) showed R2 was admitted to the facility on [DATE], with multiple diagnoses including acute cystitis, acute respiratory failure, sepsis, bacteremia, heart failure, and acute kidney failure.</p> <p>R2's MDS (Minimum Data Set) dated December 27, 2024, showed R2 has moderate cognitive impairment. The MDS continued to show R2 was dependent on facility staff for toileting hygiene.</p> <p>R2's incontinence care plan dated December 30, 2024, showed [R2] has bowel incontinence related to weakness, limited mobility, fatigue, pain, activity intolerance. The care plan continued to show multiple interventions dated December 30, 2024, including Check resident frequently and assist with toileting as needed.</p> <p>On February 10, 2025, at 10:00 AM, R2 was lying in bed with his call light activated. R2 said he activated his call light at 8:30 AM, and it was now 10:00 AM. R2 said he was waiting for his soiled incontinence brief to be changed. R2 said on February 1, 2025, R2 waited three hours for his soiled incontinence brief to be changed. R2 continued to say on multiple evenings, R2 has had to wait over three hours for his soiled incontinence brief to be changed.</p> <p>On February 10, 2025, at 10:23 AM, V8 (RN/Registered Nurse) said she provided incontinence care to R2 with the assistance of V9 (CNA/Certified Nursing Assistant). V8 said R2 had stool in his incontinence brief.</p> <p>On February 10, 2025, at 10:25 AM, V9 said the last time she checked on R2 was when she delivered his breakfast tray before 8:30 AM.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On February 10, 2025, at 1:39 PM, R2 said when he had his call light on earlier, he was waiting for his soiled incontinence brief to be changed. R2 said he waited until after breakfast to activate his call light to be changed. R2 said he had been sitting in stool from when he turned his call light on at 8:30 AM, until the staff came in to change him around 10:15 AM. R2 continued to say the only time R2 gets out of bed is when physical therapy is working with him for 30 minutes five times a week.</p> <p>The facility policy titled Incontinence Care dated March 10, 2024, showed General: Incontinence care is provided to keep residents dry and odor free as possible. It also helps in preventing skin breakdown .</p> <p>The facility's policy titled Policy: Supportive Activities of Daily Living (ADL) dated November 7, 2024, showed Policy Statement: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Procedure: . 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: . b. Mobility (turning, re-positioning, transfers, and ambulation, including walking); c. Elimination (toileting) .</p>

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<p>F 0686</p> <p>Level of Harm - 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** 45303</p> <p>Based on observation, interview, and record review, the facility failed to implement interventions to prevent a resident from acquiring a pressure ulcer. This failure resulted in R2 developing a stage 2 pressure ulcer on the left ischium. This applies to 1 of 3 residents (R2) reviewed for pressure ulcers in the sample of 6.</p> <p>The findings include:</p> <p>R2's EMR (Electronic Medical Record) showed R2 was admitted to the facility on [DATE], with multiple diagnoses including acute cystitis, acute respiratory failure, sepsis, bacteremia, heart failure, and acute kidney failure.</p> <p>R2's MDS (Minimum Data Set) dated December 27, 2024, showed R2 has moderate cognitive impairment. The MDS continued to show R2 required maximal assistance from facility staff for rolling left to right in bed and was dependent on facility staff for toileting hygiene.</p> <p>R2's skin care plan dated December 24, 2024, showed [R2] has potential impairment to skin integrity related to fragile skin, limited mobility, morbid obesity. The care plan continued to show multiple interventions dated December 24, 2024, including Assist with turning and repositioning frequently and as tolerated/needed. Keep skin clean and [NAME]. Use lotion on dry skin.</p> <p>R2's ADLs (Activities of Daily Living) care plan dated December 24, 2024, showed [R2] has an ADL self-care performance deficit related to activity intolerance, fatigue, limited mobility, weakness, low activity tolerance related to acute cystitis, atrial fibrillation, congestive heart failure, and morbid obesity. The care plan continued to show multiple interventions dated December 24, 2024, including Resident will be turned regularly while in bed. The care plan showed an intervention dated December 26, 2024, including Bed mobility: [R2] is totally dependent/extensive assistance on two staff for repositioning and turning in bed every routine round and as necessary. Low air loss mattress in use.</p> <p>R2's Nursing Admission/Re Admission Evaluation dated December 23, 2024, showed R2's Braden Scale for Predicting Pressure Risk was a 10, indicating R2 was at high risk for developing a pressure ulcer.</p> <p>The facility's Wound Report dated February 10, 2025, showed R2 had a facility acquired stage to pressure ulcer on the left ischium.</p> <p>On February 10, 2025, at 10:00 AM, R2 was lying in bed, with the head of the bed elevated. R2's call light was activated. R2 said he activated his call light at 8:30 AM, and it was now 10:00 AM, and R2 was waiting for his soiled incontinence brief to be changed. R2 said on February 1, 2025, R2 waited three hours for his soiled incontinence brief to be changed. R2 continued to say on multiple evenings, R2 has had to wait over three hours for his soiled incontinence brief to be changed.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On February 10, 2025, at 10:23 AM, V8 (RN/Registered Nurse) said she provided incontinence care to R2 with the assistance of V9 (CNA/Certified Nursing Assistant). V8 said R2 had stool in his incontinence brief.</p> <p>On February 10, 2025, at 10:25 AM, V9 said the last time she checked on R2 was when she delivered his breakfast tray before 8:30 AM.</p> <p>On February 10, 2025, at 1:39 PM, R2 said when he had his call light on earlier, he was waiting for his soiled incontinence brief to be changed. R2 said he waited until after breakfast to activate his call light to be changed. R2 said he had been sitting in stool from when he turned his call light on at 8:30 AM, until the staff came in to change him around 10:15 AM. R2 continued to say the only time R2 gets out of bed is when physical therapy is working with him for 30 minutes five times a week.</p> <p>On February 10, 2025, at 4:34 PM, R2 was lying in bed. R2 said facility staff do not turn him side to side, the only repositioning the facility does for R2 is pulling him up in bed. R2 said after staff pull him up in bed, staff leave R2 lying on his back with the head of his head elevated.</p> <p>On February 11, 2025, at 9:23 AM, R2 was lying in bed. R2 was positioned on his back with his head of the bed elevated. R2 said he had not been turned to either side by facility staff overnight.</p> <p>On February 11, 2025, at 9:31 AM, V10 (CNA) said R2 does not get out of bed unless R2 is working with physical therapy. V10 said she does not get R2 out of bed.</p> <p>On February 11, 2025, at 9:33 AM, V8 said R2 only gets out of bed when he is working with physical therapy.</p> <p>On February 11, 2025, at 9:58 AM, V11 (Physical Therapy Assistant) said R2 gets five days of physical therapy a week. V11 said he works regularly with R2. V11 said every time V11 works with R2 for physical therapy, R2 is lying in the bed and V11 gets R2 out of bed, then returns R2 to bed at the end of the session.</p> <p>On February 11, 2025, at 10:12 AM, V12 (Director of Rehab) said R2 receives physical therapy five times a week, Monday through Friday. V12 said she assisted with R2's physical therapy. V12 said when R2 is provided physical therapy, R2 is in bed and then returned to bed at the end of therapy. V12 said facility staff can safely sit R2 at the edge of the bed.</p> <p>Continuous observations were done on February 11, 2025, from 10:36 AM, to 12:29 PM, R2 was not repositioned or turned during that time. R2 remained in bed, on his back, with the head of the bed elevated.</p> <p>Intermittent observations were done on February 11, 2025, from 9:23 AM, to 11:58 AM. On February 11, 2025, at 11:56 AM, R2 said no facility staff had turned or repositioned him in bed.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On February 11, 2025, at 1:42 PM, V10 said routine checks on residents are every two hours to see if they need their incontinence brief changed. V10 said she repositions R2 when she changes his incontinence brief. V10 said she will move him side to side in bed while changing him and then returns him to his back when completed. V10 said she had changed R2's incontinence brief one time since 7:00 AM, and that was the only time she repositioned R2 in bed.</p> <p>R2's Documentation Survey Report dated February 11, 2025, for the period of December 24, 2024, to February 10, 2025, showed R2 was not repositioned in bed every shift as needed.</p> <p>The facility does not have documentation to show R2 was repositioned and/or turned in bed frequently or with routine checks.</p> <p>On February 10, 2025, at 4:15 PM, V6 (Wound Nurse Practitioner) said V6 assessed and evaluated R2 on February 6, 2025, for a new stage 2 pressure ulcer of the left ischium. V6 said he reviewed the etiology of R2's wound and R2 had been sitting in bed for quite a while. V6 said R2's prolonged sitting is what caused the ulceration. V6 said the ischium is also called the sit bone. V6 said prolonged exposure to stool could also be a contributing factor to R2 developing a pressure ulcer. V6 said his expectation is for facility staff to assist R2 with turning in bed and offloading R2's wound. V6 said proper repositioning of R2 could have prevented R2 from developing a pressure ulcer. V6 continued to say if facility staff followed preventative measures, it should prevent a wound from developing. V6 said he documented in his progress note for R2 to avoid direct pressure to the wound site. V6 continued to say V6's expectation is for facility staff to off-load R2's wound by turning in bed.</p> <p>A wound care note dated February 6, 2025, by V6 showed Wound Assessments: Wound number one, left ischial is a stage 2 pressure injury pressure ulcer and has received a status of not healed. Initial wound encounter measurements are 8.5 cm (centimeters) length by 7.5 cm width by 0.1 cm depth, with an area of 63.75 sq cm (square centimeter) and a volume of 6.375 cubic cm . Additional Orders: . Off-Loading: Facility Injury Prevention Protocol; Wheelchair Pressure Redistribution Cushion per Facility Protocol; Avoid direct pressure to wound site .</p> <p>The facility's policy titled Policy: Wound Prevention and Healing dated June 1, 2024, showed Policy Statement: To provide wound care treatments/services (using a multidisciplinary approach) based on evidence-based standards of care under the direction of a physician. 1. Risk Assessment and Prevention: a. Braden Scale will be completed upon admission, readmission, quarterly, and when there is a change in condition by a licensed or registered professional nurse. b. Braden scale will be completed to determine the patient's level of risk and implement interventions to prevent development of pressure injuries .</p> <p>The facility's policy titled Policy: Supportive Activities of Daily Living (ADL) dated November 7, 2024, showed Policy Statement: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Procedure: . 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: . b. Mobility (turning, re-positioning, transfers and ambulation, including walking); c. Elimination (toileting) .</p>		