STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145473	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Orchard Valley	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)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to assess a resident after an unwitnessed fall. This failure resulted in a delay of treatment for R1 who sustained subdural hematoma after a fall incident. This applies to 1 of 3 residents (R1) reviewed for assessments in the sample of 3. The findings include:R1's EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE], with diagnoses that included metabolic encephalopathy, delirium due to known physiological condition, unsteadiness on feet, unspecified lack of coordination, unspecified abnormal gait and mobility, muscle weakness, cognitive communicative deficit, and vascular dementia moderate without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R1's MDS (Minimum Data Set) dated September 11, 2025, shows R1 had severely impaired cognition and required partial/moderate staff assistance to go from sitting to standing, from chair to bed, and getting on and off toilet. R1's care plan shows R1 had impaired cognition and thought process related to his diagnosis of dementia as evidenced by poor temporal orientation, difficulty with recall and confusion. R1's cognitive assessment shows he had severe cognitive impairment. Interventions included monitor, document, and report to physician any changes in cognitive function, specifically changes in decision making, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status.R1's progress notes and EMR (Electronic Medical Record) were reviewed for nursing assessments and documentation post fall. The following were identified as the only documentation completed: On September 11, 2025, V9 (RN/Registered Nurse) was the nurse on duty when R1 fell. V9 completed a Fall Event, a progress note about the fall, and a fall assessment. The fall event dated September 11, 2025, at 7:02 PM showed the location of the fall, what resident was doing prior to the fall, when resident was last observed, when resident was last toileted, resident's statement, resident's mental status prior to fall, any deviation from resident's usual mental status, did the resident hit his head, have resident smile to assess facial muscle, extremity grasp, pupil response, ability to respond to name, ambulatory status, footwear, pain assessment, range of motion in extremities, and full body observation.On September 12, 2025, at 6:01 AM, The V18 (LPN/Licensed Practical Nurse) was the night shift nurse, and she documented a skilled charting note. Skilled charting included vital signs, orientation, recent change in disorientation, recent change in confusion, functional status, bladder function, bowel function, skin assessment, respiratory, cardiovascular, edema, pain, new orders, medication orders, and skilled services.On September 13, 2025, at 7:31 AM, a nurse completed the Follow up Documentation Falls form in the EMR. The Follow up documentation falls shows R1's temperature, heart rate, blood pressure, oxygenation, injury, function, cognitive status, and orders.On September 14, 15, and 16, 2025, there were no progress notes and no documentation of any assessment done on R1. The next progress note was written on September 17, 2025 at 10:40 AM, and it showed R1 was fatigued that morning and required more staff assistance for transfers and ambulation.On November 18, 2025, at 8:55 AM, V2 (DON/Director of Nursing) was unable to provide any neuro assessments done on R1 after September 11, 2025.On November 17, 2025, at 2:49 PM, V7 (R1's POA/Power of Attorney) said she was notified by the nurse on September 11, 2025, that R1 had an unwitnessed fall. V7 said she specifically asked the nurse if (continued on next page)

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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F 0684 Level of Harm - Actual harm Residents Affected - Few	R1 hit his head, and the nurse told her he had asked R1, and he said no. V7 was concerned that R1 was confused and may not have been able to say if he hit his head or not. V7 said she told the nurse she wanted R1 sent to the hospital for evaluation which the facility did not do. V7 said on September 17, 2025, R1 was not able to talk and was barely able to move. At this point, V7 said she told V11 (Previous DON/Director) that she wanted R1 sent out because she was concerned that R1 hit his head when he fell, and this was the result of that fall. V11 responded saying she had done a neuro (Neurological) assessment and based on that assessment R1 was fine. V7 questioned her and asked what did her neuro assessment consist of? V11 said, she checked R1's pupils and said she felt R1's current status was most likely because he had a UTI (Urinary Tract Infection). The next day (September 18), V7 said another family member went to check on R1 at the facility and called her to let her know R1 was still not able to talk or even able to move in the bed. V7 spoke to V11 and told her she wanted R1 sent out. V11 called V8 (Physician) and placed V8 on speaker phone, so V7 and family member could hear that conversation. V8 told V11 send (R1) to the hospital now. V7 said they called 911 to have R1 sent to the ER. V7 said she was later called by the ambulance staff, and they made her aware that due to R1's condition, they could not take R1 to the requested hospital but took him to the closest hospital to the facility due to his current condition. R1 had a CT scan (Computerized Tomography) in the ER that showed he had major brain bleed on both sides of his head and was transferred to another hospital where he had surgery the next day.R1's Emergency Department Physician report dated September 18, 2025 at 4:44 PM shows R1 presented with altered mental status following a likely fall one week prior. Head CT revealed acute on chronic bilateral subdural hematomas (12 mm right, 20 mm left) and bilateral subdural hygromas with significant mass effect and effacement of cerebral sulci and ventricles. Trauma surgery and neurosurgery were consulted R1 was accepted for transfer to another hospital for definitive trauma and neurosurgical management. The report also shows currently R1 was nonverbal. The report further shows R1's daughters reported a fall last week followed by a change from his baseline mental status.On November 18, 2025, at 10:37 AM, V8 (Physician) stated when there is an unwitnessed fall and staff are not sure if resident hit their head or not, he would send the resident to the hospital for an evaluation. If there were any changes in their mental status, they should send the resident out for an evaluation immediately. V8 also stated R1 was on Aspirin 325 mg (milligrams) daily, and at that dose it would be considered an anticoagulant, and anyone taking an anticoagulant, needs to be sent out immediately. Knowing R1 was on the memory care unit with impaired cognition and on Aspirin, he would have sent R1 to the ER for evaluation right away, but the facility contacted V12 (NP/Nurse Practitioner) on the day of the fall. V8 said he saw R1 on the day he was sent out to the local hospital. It was reported to him by the nursing staff and the family that R1 had a change of condition and had been more lethargic since the day before, and the staff also stated they were having trouble transferring him. V8 said based on what he was told, he spoke with V11 (Previous DON/Director of Nursing) and told her to send R1 to the ER immediately. V8 said he called the facility approximately 3 hours later to follow up and found out that V11 had not sent R1 to the ER. V8 said he was really upset. V8 said V11 tried to refute what he said, claiming that V8 had told her to just order some labs. V8 said he did not and told her to send R1 to the ER where they could evaluate him and run test if necessary. V8 told V11 to start the process and get R1 transferred to the hospital immediately. V8 said he was later made aware that due to R1's condition the paramedics rerouted R1 to the closest hospital and not the hospital requested by the family. R1 was later transferred to another hospital due to a brain bleed. V8 said he was not aware that the facility was not doing neuro (neurological) assessments on R1 and if they would have done the assessments after the fall, they may have caught the brain bleed earlier.On November 11, 2025, at 10:54 AM, V12 (Nurse Practitioner) said she was unsure if the nurse who called her to report R1's fall told her if it was a witnessed or unwitnessed fall. V12 said she saw R1 the next day and he denied having had a fall the day before. V12 said if it was an unwitnessed fall, the staff should be doing neuro checks for 72 hours post fall. V12 said she saw R1 on September 17, (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	2025, and R1 was more fatigued, staff were having difficulty transferring R1. V12 said she thought R1 might have a UTI (Urinary Tract Infection), so she ordered labs and an UA C&S (Urinalysis Culture and Sensitivity). The preliminary urinalysis was negative for UTI. R1 was sent out to the ER the next day by V8 (Physician).On November 18, 2025, at 8:21 AM, V2 (DON/Director of Nursing) said after a fall, we call a fall huddle where everyone gets together to determine how and why this fall happened. The nurse should do a head-to-toe assessment, if the resident hit their head or if they are not sure about the resident hitting their head then they should do neuro assessments and call the physician. The nurse needs to provide the physician or Nurse Practitioner with the fall assessments to determine if the resident should be sent out to the hospital. The nurse should report to the oncoming nurse the information about the fall, and they should continue to assess the resident by documenting in a progress note, fall assessment under the assessment tab in the EMR (electronic medical record). V2 said she was unsure how long the assessments should continue, because she is new to this facility and is not sure of their policy but said neuro assessment needs to be done for 72 hours post fall. V2 said if a resident is confused and the nurse is unsure if resident hit their head, and is on an anticoagulant, then the resident needs to be sent out immediately to the ER or evaluation.On November 19, 2025, at 2:35 PM, followed V20 (CNA/Certified Nursing Assistant) into the dining room where R1 fell. In the back right corner of the dining room, there was a large wooden stand with cabinet doors that held a large fish tank. Along the same wall on the left-hand corner, V20 said they had an activity table with activity sheets and magazines the residents could read. That table was not there during this investigation. V20 said she was cleaning a table on the right-hand side of the dining room in front of the fish tank and R1 was standing few feet away behind her and suddenly she heard a noise and turned around and saw R1 sitting on the floor with his head against the wooden cabinet holding the fish tank and his feet to the left of the fish tank in front of the activity table. V20 called for the nurse who came and assessed R1. V20 could not say if R1 hit his head or not.On November 18, 2025, at 3:11 PM, V9 (RN/Registered Nurse) said he was the nurse on duty when R1 fell. He was passing medications when the CNA (Certified Nursing Assistant) called out to him to let him know R1 had fallen in the dining room. V9 said he went to the dining room and saw R1 on the floor. R1 was ambulatory at the time of the fall but was not able to say what happened due to his confusion which was his baseline. V9 said he did a head-to-toe assessment, checked ROM (Range of motion) in all four extremities, and did a neuro assessment. V9 said there were no concerns. R1 was assisted by two staff to a chair. V9 said he notified V12 (NP/Nurse Practitioner) told her R1 had an unwitnessed fall in the dining room, gave her results of his assessment, and there were no new orders. V9 said a head-to-toe assessment was done initially, and neuro assessment as per the paper (every 15 minutes x 1 hour, 30 minutes x whatever the neuro assessment paper says to do). V9 said the nurse should document a progress note every 8 hours or once every shift unless something changes then the doctor or NP should be notified. V9 said he was off the next four days after R1's fall, when he returned, he was told they might be sending R1 out to the hospital for a change in condition. V9 could not remember if it was V10 (dayshift nurse) or V11 (Previous DON) that told him that about R1's change of condition. On November 19, 2025, at 11:22 AM, V15 (LPN) said when there is an unwitnessed fall, she would do a head-to-toe assessment and she would also do the neuro checks (assessment) as per schedule (every 15 minutes x 4, every 30 minutes x2, .).On November 19, 2025, at 12:26 PM, V17 (LPN/Licensed Practical Nurse) said when there is an unwitnessed fall, he would first assess the resident by doing a head-to-toe assessment and then do a neuro assessment according to the schedule on the sheet (15 minutes x how many ever times.).On November 19, 2025, at 12:35 PM, V18 (LPN) said when a resident falls, we do a head-to-toe assessment, if they hit their head, we do a neuro assessment, and they are automatically sent out to the ER for evaluation. If we are not sure if the resident hit their head, we start the neuro assessment and call the physician. Neuro assessments are documented on a paper form. V18 said she thinks they must chart on the resident for three days after the fall. Facility provided their 72-hour Neurological Flow Sheet. The form showed (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	neuro checks are to be done every 15 minutes times 4, 30 minutes times 2, every hour times 6, and every 8 hours times 8.Facility provided their incident report for R1. Facility started an investigation on September 19, 2025, for R1's fall on September 11, 2025. The report was sent to IDPH (Illinois Department of Public Health). The final report was faxed to IDPH on September 24, 2025. The investigation showed neuro checks were initiated and completed. The supporting documents the facility presented did not include any documented neuro checks after September 11, 2025. The investigation showed R1 had a change in condition on September 18, 2025, but the progress note dated September 17, 2025, showed a nurse reached out the Nurse Practitioner due to increased fatigue and change in R1's transfer and mobility status.Facility provided their policy, titled, Fall Prevention and Management dated October 29, 2021. The policy identified. #3 Procedure for Post-Fall Management. c. perform physical assessments including: i. head to toe assessment, ii. Vital signs, pulse, respiratory rate, pulse ox, blood pressure, and pain, iii. Range of motion, iv. Neurological Assessment as indicated.