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	06/04/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 observation, interview, and record review, the facility failed to implement the physician-ordered plan of care and follow interventions intended to prevent and manage constipation for a resident with declining renal function and Stage IV chronic kidney disease. The facility failed to ensure the resident received appropriate assessments, dietary interventions, and as-needed constipation treatments despite documented evidence of ongoing bowel elimination concerns. This applies to 1 of 4 residents (R4) reviewed for bowel elimination.The Findings include:Review of the electronic medical record (EMR) showed that R4, a [AGE] year-old resident, was admitted to the facility on [DATE]. Diagnoses included hypertension, type 2 diabetes mellitus, cerebral infarction with right-sided hemiplegia and hemiparesis, peripheral vascular disease, iron deficiency anemia, Stage IV chronic kidney disease (CKD), acute kidney injury, malignant neoplasm of the bladder, and obesity.The Minimum Data Set (MDS) assessment dated [DATE], showed that R4 was cognitively intact and required substantial staff assistance with activities of daily living (ADLs).Review of the Physician Order Sheet (POS) for June 2026 showed an order for a carbohydrate-controlled diet. The POS also included a routine order for Senna-S daily for constipation, initiated on May 3, 2024. Additional as-needed (PRN) constipation medications included Dulcolax suppository 10 mg every 24 hours as needed for constipation, ordered May 1, 2024, and MiraLAX 17 grams every 24 hours as needed for constipation, ordered March 24, 2026.Review of nephrology nurse practitioner (NP-V6) progress notes dated May 21, 2026, documented that R4's renal function was declining and that the resident had elected not to undergo dialysis. The notes identified Stage IV CKD and included interventions to encourage fluid intake, avoid nephrotoxic agents, monitor bilateral nephrolithiasis, and address declining renal function. Documentation further noted a carbon dioxide (CO2) level of 12, consistent with metabolic acidosis likely secondary to CKD. The plan of care was to ensure R4 received a high-fiber diet and to prevent constipation, noting that constipation could contribute to inflammation and toxin accumulation and that bowel management should include increased dietary fiber and appropriate treatment of constipation.Review of the bowel movement monitoring record from May 4, 2026, through June 1, 2026, showed documentation of only one large bowel movement, ten medium bowel movements, five small bowel movements, and twenty-nine entries documented as NA.On June 2, 2026, at 2:30 p.m., V2 (Director of Nursing) and V10 (Certified Nursing Assistant) stated that an NA entry indicated a bowel movement that was too small to measure and consisted only of a smear adhering to the brief.Review of the electronic Medication Administration Record (eMAR) for May 2026 showed that neither the PRN Dulcolax suppository nor the PRN MiraLAX was administered during the month. On June 2, 2026, V2 confirmed that no PRN constipation medications had been provided to R4 during May 2026 despite the bowel movement documentation. Review further showed that the high-fiber dietary intervention ordered by the nephrology provider had not been implemented.On June 1, 2026, at 12:30 p.m., V5 (Registered Dietitian) stated that R4 had not been assessed or evaluated for implementation of a high-fiber diet and had not been placed on a high-fiber diet as recommended by the nephrology provider.On June 1, 2026, at 12:15 p.m., R4 was observed lying in bed, alert and oriented to person, place, time, and situation. R4 stated that she consistently experienced constipation and that when (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 - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	bowel movements occurred, they were very small and almost none. R4 reported informing staff, including nurses, about her constipation concerns but was repeatedly advised only to drink more water. R4 stated that PRN medications for constipation were not provided and that increasing water intake did not resolve the problem. R4 further stated that V3 (Nurse) had been the only staff member who attempted to assist with her constipation concerns, although V3 rarely cared for her.On June 2, 2026, at 1:10 p.m., V3 stated that R4 had complained of constipation to her on the latter part of May 2026.On June 4, 2026, at 11:30 a.m., NP-V6 stated that she evaluated R4 on May 21, 2026, and that the plan of care included a high-fiber diet and prevention of constipation due to the resident's declining renal function. V6 stated that constipation could contribute to toxin accumulation and negatively affect kidney function. V6 further stated that R4 should have received PRN constipation medication based on the documented bowel elimination pattern and that additional interventions, such as a Fleet enema or referral to a gastroenterologist, might be necessary when constipation persists.Review of the facility's Bowel Program Policy, dated August 6, 2020, stated that bowel management interventions are intended to promote regular, voluntary, controlled bowel evacuations of normal consistency and that normal bowel function involves passage of soft, formed stools in adequate volume without straining.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that individualized interventions were implemented to address identified causative and triggering factors associated with a pattern of falls. The facility also failed to identify and address recurrent urinary tract infections (UTIs) and catheter management issues that contributed to repeated falls. This failure resulted in R1 sustaining a right 5th rib fracture following a fall on May 18, 2026. This applies to 1 of 3 residents (R1) reviewed for falls.The Findings Include: Review of the Electronic Medical Record (EMR) showed that R1, an [AGE] year-old female, was admitted to the facility on [DATE]. Diagnoses included a recent right 5th rib fracture and a current urinary tract infection (UTI). Chronic diagnoses included Type 2 diabetes mellitus, hypertension, dementia, abnormalities of gait and mobility, muscle disorder, lack of coordination, muscle weakness, anxiety disorder, senile degeneration of the brain, obstructive and reflux uropathy, chronic kidney disease stage III, history of UTIs, history of left femur fracture, left hip joint replacement, and history of subdural hemorrhage.The Minimum Data Set (MDS) assessment dated [DATE], indicated that R1 was moderately cognitively impaired and required substantial assistance from staff for activities of daily living (ADLs).On June 1, 2026, at approximately 10:30 a.m., R1 was observed lying in bed during indwelling catheter care. Staff members V8 (Licensed Practical Nurse) and V9 (Certified Nursing Assistant) provided catheter care. During the care, R1 complained of right-sided rib pain and stated she was unable to turn onto her left side due to discomfort. V9 reported that the pain was related to the rib fracture sustained during a fall on May 18, 2026. R1 stated that she had been attempting to go to the bathroom when she lost her balance and fell to the floor.Review of the Fall Risk assessment dated [DATE], showed that R1 was identified as being at high risk for falls.Review of the facility's incident reports from January 2026 through June 2, 2026, showed that R1 experienced four falls: -January 10, 2026 - Sent to the hospital for evaluation of a head injury. -February 16, 2026 - Sent to the hospital for a head injury with a laceration requiring sutures. -April 27, 2026 - Sent to the hospital for evaluation of a head hematoma. -May 18, 2026 - Sent to the hospital and diagnosed with a right 5th rib fracture.Further reviews of EMR showed that R1 had confirmed UTIs associated with three of the four fall incidents. The EMR documented recurrent UTIs on February 16, 2026, April 27, 2026, and May 18, 2026. R1 also had a documented history of recurrent UTIs.Review of R1's care plan dated May 25, 2026, showed interventions originally initiated on August 15, 2025, addressing chronic indwelling catheter use and a significant history of UTIs, including sepsis and vancomycin-resistant enterococci (VRE) urinary infections. However, the care plan lacked individualized interventions based on the root cause analysis of R1's repeated falls. Despite documentation showing that R1 attempted to toilet during the fall incidents and had concurrent urinary infections, the care plan did not include interventions to address recurrent UTIs, catheter management, increased monitoring during infection episodes, or other measures aimed at reducing fall risk related to infection-associated confusion and urgency.On June 2, 2026, at approximately 12:45 p.m., V7 (R1's Attending Physician) stated that UTIs can increase confusion and contributed to R1's falls, including the fall that resulted in the right 5th rib fracture.Review of the facility's Fall Prevention Policy dated October 29, 2021, indicated that the facility is committed to reducing the risk, frequency, and consequences of falls, including falls resulting in injury. The policy further stated that residents identified as high risk for falls should receive individualized interventions that address identified risk factors and that intervention plans should be developed based on fall assessments, investigations of surrounding falls, and resident outcomes.The facility failed to implement individualized interventions addressing the identified contributing factors of recurrent UTIs, toileting needs, and infection-related confusion despite multiple falls, repeated hospitalizations, and a fall that resulted in rib fracture.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, the facility failed to provide catheter care in accordance with accepted standards of practice by failing to cleanse the urethral meatus during indwelling urinary catheter care. The facility also failed to follow a physician's order to change an indwelling urinary catheter when a urinary tract infection (UTI) occurred. This applies to 2 of 3 residents (R1 and R3) reviewed for indwelling urinary catheter care.Findings include:The Electronic Medical Record (EMR) showed that R1, an [AGE] year-old female, was admitted to the facility on [DATE]. Her current diagnoses included a right fifth rib fracture and urinary tract infection (UTI). Chronic diagnoses included type 2 diabetes mellitus, hypertension, dementia, abnormalities of gait and mobility, muscle disorder, lack of coordination, muscle weakness, anxiety disorder, senile degeneration of the brain, obstructive and reflux uropathy, chronic kidney disease stage III, history of recurrent UTIs, left femur fracture, left hip joint replacement, and history of subdural hemorrhage.The Minimum Data Set (MDS) assessment dated [DATE], showed that R1 was moderately cognitively impaired and required substantial staff assistance with Activities of Daily Living (ADLs).The EMR showed that R1 had a history of recurrent UTIs. During the four-month period from January 2026 through May 2026, R1 developed three UTIs, with documented occurrences on February 16, 2026, April 27, 2026, and May 18, 2026.Review of R1's Physician Order Sheet (POS) for June 2026 showed a physician's order directing staff to change the indwelling urinary catheter when an infection occurred. Review of the EMR, including treatment records, medication administration records, and progress notes for the previous four months, failed to show documentation that R1's indwelling urinary catheter was changed following any of the documented UTIs. On June 2, 2026, at approximately 1:00 p.m., V2 (Director of Nursing) confirmed that there was no documentation to show the catheter had been changed when R1 experienced the UTIs.On June 1 and June 2, 2026, between approximately 10:30 a.m. and 11:00 a.m., observations were conducted of indwelling urinary catheter care provided to R1 and R3. V8 (Licensed Practical Nurse) and V9 (Certified Nursing Assistant) provided catheter care to R1. V10 (Certified Nursing Assistant) provided catheter care to R3.During the observations, V8, V9, and V10 failed to cleanse the urethral meatus during catheter care. Specifically, V9 failed to separate R1's inner labial folds to ensure cleansing of the urinary meatus. V10 failed to cleanse the tip of R3's penis, including the urinary meatus, during catheter care. The urinary meatus is the entry site for an indwelling urinary catheter and requires routine cleansing to reduce the risk of infection.Additionally, observation of R3 showed an approximately two-inch erosion extending from the penile tip toward the shaft. During interview, R3 stated that he had recently been readmitted to the facility following hospitalization and was currently receiving antibiotics for a urinary tract infection.Review of the EMR showed that R3, a [AGE] year-old male, was admitted to the facility on [DATE]. Diagnoses included type 2 diabetes mellitus with diabetic neuropathy, cervical spinal stenosis, arthritis, cervical disc disorder, spondylopathy, spondylosis, neurogenic bladder dysfunction, chronic kidney disease, atherosclerotic heart disease, congestive heart failure, major depressive disorder, morbid obesity, vertebral osteomyelitis, stage IV sacral pressure ulcer, stage III right heel pressure ulcer, paraplegia, colostomy status, chronic pain, sepsis, hematuria, tubulointerstitial nephritis, urogenital candidiasis, and extended-spectrum beta-lactamase (ESBL) infection.The MDS assessment dated [DATE], showed that R3 was cognitively intact and required substantial staff assistance with ADLs.Review of R3's care plan dated June 1, 2026, documented that R3 had been hospitalized in May 2026 with diagnoses that included hematuria and UTI.Review of the facility's Indwelling Catheter Policy, dated June 25, 2020, showed that residents with indwelling urinary catheters should receive catheter care consistent with standards of practice to prevent urinary tract infections. The policy further directed staff to thoroughly cleanse the urethral meatus during catheter care.