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	03/21/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on interview and record review the facility failed to protect a resident's right to be free from physical abuse. This applies to 2 of 3 residents (R67 and R124) reviewed for abuse in a sample of 32. Findings include: R124's MDS (Minimum Data Set) dated 01/24/25 shows she is cognitively intact. On 03/19/25 at 10:21 AM, R124 stated R67 stepped on her toe, then she pushed him. R124 stated R67 then pushed her back. R124 stated she spoke to V1 Administrator the following day about the physical altercation. R124 stated V1 Administrator informed her he sent a report to [NAME] regarding the incident. R67's MDS (Minimum Data Set) dated 12/4/24 shows he is cognitively intact. On 03/20/25 09:52 AM, R67 stated he was assisting R124's roommate back to her room when R124 hit him with a grabber twice. R67 stated R124 told him to stay out of their room. R67 stated he never pushed R124. R67 stated he had stepped on R124's foot by accident on another occasion for which he apologized. R67 stated R124 had accepted his apology. On 3/6/25 V14 Social Services Director progress note documents a wellness check post incident to assess how R67's was doing and to determine any social, emotional or mental health needs that require attention. On 03/20/25 11:35 AM, V14 Social Services Director stated V1 Administrator / Abuse Coordinator informed her R67 ran over R124's foot. V14 Social Services Director stated she was instructed by V1 Administrator to visit R67 because R124 had struck him with something. V14 stated she checked in on R67 to assure he continued to feel safe in the facility. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/20/25 11:53 AM, V20 RN (Registered Nurse) stated V1 Administrator instructed V20 to do a head-to-toe assessment on R67. V20 stated V1 instructed her on the wording in her progress as to the purpose for R67's head to toe assessment due to the unwanted contact with another resident. V20 stated she was not the nurse for R67 or R124 at the time of their incident. V20 stated V2 DON (Director of Nursing) was present when V1 instructed her to complete R67's head to toe assessment and how to document. V20 stated she was not informed of what R67 was hit with. On 03/20/25 at 01:04 PM, V22 CNA (Certified Nursing Assistant) stated she found R67 and R124 yelling at each other. R124 was telling R67 to get of her room. V22 stated R124 had a grabber in her hand, but she did not see any physical resident to resident altercation. V22 stated she informed V23 LPN (Licensed Practical Nurse) of R67 and R124's incident. On 03/20/25 at 01:18 PM, V23 LPN stated she was the nurse caring for R124 when she and R67 had the occurrence. V22 CNA reported the occurrence to her, and she reported it to the DON. V23 stated she was not aware or informed of either resident being hit or pushed. On 03/20/25 at 02:03 PM, V2 DON stated V23 LPN informed her that R124 wanted to speak with the Administrator in the morning following occurrence. V2 DON stated she instructed V23 LPN to keep R67 and R124 away from each other. On 03/18/25 at 01:11 PM, V1 stated he had spoken to R124 regarding a misunderstanding about lottery ticket she had another resident purchase for her. V1 stated he submitted a reportable to the department of health related to the incident. On 03/20/25 at 02:09 PM, V1 Administrator stated R67 reported to him that R124 actually hit him. V1 stated he spoke to R124 after being informed by surveyor of R124's allegation of R67 stepping on her foot and her pushing him. Review of the initial report incident brief description stated R67 notified the V1 Administrator / Abuse Coordinator that sometime after 5pm on 03/04/25 R124 made an unwanted contact with him. The investigation report interview with R67 states R124 was mad that R67 had purchased the wrong lottery ticket. When R67 tried to leave R124's room, R124 touched him. In V1 Administrator's interview with R124, V1 documented 124's denial of touching R67. The undated facility provided Admissions Packet- Resident Rights states residents have the right to be free from physical abuse. The undated facility provided Abuse Prevention Program- Policy states physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46003 Based on interview and record review the facility failed to submit reports of abuse to the Illinois Department of Public Health within the mandated timeframes. This applies to 1 of 3 residents(R36) reviewed for abuse in a sample of 32. Findings include: R36's MDS (Minimum Data Set) dated 02/10/25 shows she is cognitively intact. On 03/18/25 at 11:55 AM, R36 stated she had money, a debit card, an ID (identification card), and her birth certificate stolen from her purse. V36 stated she thought V21 CNA (Certified Nursing Assistant) might have taken them. R36 stated she had already reported the theft to V1 Administrator / Abuse Coordinator, but he did not do anything, On 03/18/25 01:11 PM, V1 Administrator stated R36 had previously informed him she had missing money and an ID. V1 stated residents are encouraged to give cash to the business office to be secured. V1 stated Social Services was working on getting R36 a replacement ID. V1 stated he had no knowledge of the other missing items. V1 stated he had no way to verify what was missing. On 03/20/25 at 11:35 AM, V14 Social Services Director stated V1 Administrator will make her aware of missing or stolen items. We will search the room and speak with the family of the resident. V14 stated V1 informed her R36 was missing money. She had not been informed of any other missing items. V14 stated V1 instructed her to check in on R36 to assure she felt safe in the facility. On 03/20/25 at 01:24 PM, V21 CNA stated about three weeks he was not assigned to R36 but was instructed to assist to put on her pants. V21 stated he assisted her to put her pants on and left the room immediately after. V21 stated he was not questioned and suspended by V1 until 3/18/25 at about 2pm. On 03/20/25 at 02:09 PM, V1 Administrator / Abuse Coordinator stated when R36 originally came to her she stated she was missing a link cark and ID but did not accuse anyone. V1 stated R36 came to her again a week or two later and said someone stole her items but did not say who. V1 stated he did not recall the dates when R36 came. V1 stated he did not document anything related to R36's complaints of her missing items. V1 stated when someone claims something is stolen, he tries to verify the validity. V1 stated R36 is cognitively intact, but her claims seemed to be a stretch. V1 stated the process of when a resident reports theft is an initial report to IDPH (Illinois Department of Health) is submitted. V1 stated at minimum a grievance form should have been done. V1 stated as soon as she said stolen, he should have done a report. The initial report sent to IDPH showed the Incident date as 3/18/2025 and showed .made an allegation of theft by a CNA . The facility's Final Report for R36 showed abuse was not substantiated, and that Social services is also assisting resident in coordinating replacement state ID and birth certificate. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The undated facility provided Abuse Prevention Program- Policy states that after an allegation of abuse, neglect, mistreatment, misappropriation of resident property or exploitation, the administrator or designee will initiate an investigation into the allegation. An initial report to the state licensing agency, IDPH shall be made immediately after the resident has been assessed and the alleged perpetrator removed.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on interview and record review the facility failed to immediately initiate an investigation into allegations of abuse to assure the wellbeing of a resident. This applies to 1 of 3 residents(R124) reviewed for abuse in a sample of 32. Findings include: R124's MDS (Minimum Data Set) dated 01/24/25 shows she is cognitively intact. On 03/19/25 at 10:21 AM, R124 stated she had an altercation with R67. R124 stated she told R67 she did not want him in the room because she had belongings come up missing after his visits with her roommate. R124 stated R67 purposely stepped on her already injured toe. R124 stated she then pushed R67, and he pushed her back. R124 stated she had informed V1 Administrator / Abuse Coordinator the day after the occurrence. R124 stated V1 informed her he sent a report regarding the occurrence to [NAME]. On 03/19/25 at 10:35 AM, the surveyor notified V1 Administrator of R124's accusation against R67. On 03/20/25 at 11:35 AM, V14 Social Services Director stated V1 Administrator informed her of the previous altercation between R124 and R67 in which R67 ran over R124's foot and hurt her. On 03/20/25 at 01:04 PM, V22 CNA stated on the day of R124 and R67 altercation she saw the two residents yelling at each other and R124 telling R67 to get out of her room. V22 stated there was a visitor and an agency CNA who's names she did not know who witnessed the occurrence. V22 CNA stated V1 Administrator spoke with her the following Monday to ask of her knowledge of the occurrence between R124 and R67. V22 stated V1 called her on 3/20/25 and asked her the same questions. On 03/20/25 at 01:18 PM, V23 LPN (Licensed Practical Nurse) stated she was R124's nurse on 3/4/25 when the occurrence happened. V23 stated V22 CNA informed her of R124 and R67's altercation. V23 LPN stated when she went to check on R124, R124 was crying that she did not want R67 coming in her room. V23 stated she reported the occurrence to V2 DON (Director of Nursing) who instructed her to keep R67 out of R124's room. V23 LPN stated she did not recall documenting the occurrence. On 03/20/25 at 02:09 PM, V1 (Administrator)stated that R124 and R67 had a disagreement regarding lottery tickets in which both residents made allegations of a physical altercation. V1 stated he submitted a new report to IDPH (Illinois Department of Public Health) regarding R124's allegation. No nursing documentation was noted in R124's EMR (Electronic Medical Record) regarding any resident-to-resident occurrence. No nursing assessment was noted for an altercation related to R124. The report submitted to IDPH on 3/19/25 at 12:52 PM inaccurately documents surveyor informed V1 Administrator / Abuse Coordinator of R124's allegation at 11:00 PM. In the brief description it states R124 was unable to provide a date or time that R67 allegedly stepped on her foot. R124 witness statement wasn't done until 3/20/25. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The undated facility provided Abuse Prevention Training Program states an initial report shall to the state licensing agency, IDPH shall be made immediately after the resident has been assessed and the alleged perpetrator removed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944 Based on observation, interview, and record review, the facility failed to assist residents who require assistance with their ADLs (Activities of Daily Living). This applies to 5 out of 5 (R71, R90, R117, R109, and R19) residents reviewed for ADLs in a sample of 32. The findings include: 1. On 3/19/2025 at 3:50 PM, R109 was walking in and out of his room aimlessly, trying to hold his pants up from the waist. R109 was confused and unable to express his needs. R109's incontinence brief could be visibly observed that it had partially fallen off and was bunched on his left mid-thigh area. R109's pants were visibly soiled and had a foul urine odor. R109's floor next to his bed was visibly soiled. V10 (RN) was asked to assess and assist R109 with incontinence care. V10 said she was unsure when he was last provided with incontinence care but would try to find a CNA. R109 stayed sitting on his bed confused and repeatedly said he was sorry. At 4:20 PM, V10 was again asked to assist R109 with his soiled clothing and incontinence brief. On 3/18/2025 at 10:55 AM and 3/20/2025 at 9:55 AM, R109 was observed in the dining room. R109 had foul mouth odor and his teeth had residue buildup. R109 was severely cognitively impaired and unable to express his needs. R109's MDS dated [DATE] verified he was severely cognitively impaired and required staff to assist him with his ADLs. R109's ADL care plan said R109 was unable to perform self-care including toileting because of progressive confusion and impaired cognition related to his dementia. On 3/20/2025 at 12:25 PM, V2 (Director of Nursing/DON) said she expected the nursing staff to provide incontinence care as per the facility's policy. 2. On 3/18/2025 at 10:20 AM, R71 was in bed, and his hair was unkept. R71 said he needed staff help with showers because he was unable to use his left side because of a stroke. R71 said he last received a shower the first week of the month. On 3/20/2025 at 10:00 AM, R71 said he still had not received a shower. R71 said he was supposed to receive two weekly showers on Tuesdays and Fridays. R71 continued to say he also wanted staff to help him with his oral care. R71's teeth had buildup residue. R71 said he could not recall the last time the staff brushed or swabbed his mouth. V12 (Restorative Aide) was asked to assess R71's fingernails. R71's nails were long, unkept, and had a brown substance underneath them. R71's MDS (Minimum Data Set) dated 2/10/2025 said R71 required substantial to maximal staff assistance with his personal and oral hygiene care. The MDS also said R71 was dependent on staff for showers. R71's EMR (Electronic Medical Record) showed his last recorded shower was done on 3/04/2025 (two weeks earlier). 3. On 3/18/2025 at 10:50 AM, R117 was in bed and had overgrown facial hair underneath her chin. R117's nails were long and had a brown substance underneath them. R117's teeth had thick residue buildup. R117 was cognitively impaired and unable to express her needs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/20/2025 at 10:05 AM, R117 still had overgrown facial hair, her nails unkept and teeth unbrushed. V12 and V5 (Restorative Nurse) were asked to assess R117. They said they were unsure when R117 was last provided oral care. V5 said R117 needed her overgrown facial hair to be removed. V5 continued to say that nursing staff should be providing dependent residents with oral care at least daily, showers twice a week as scheduled, and grooming care daily and as needed. R117's MDS dated [DATE] said R117 required substantial to maximal staff assistance with her personal and oral hygiene care. 4. On 3/18/2025 at 1:00 PM, R90 was in bed eating his lunch. R90's fingernails were long, unkept, and filled with thick brown residue buildup underneath. On 3/20/2025 at 10:10 AM, V12 and V5 were asked to assess R90's fingernails. R90's hands were severely contracted, and his hands were in a fixed fist position. V12 said R90's fingernails were too long that they were causing indentations to the palm of his hands. R90 said he wanted his fingernails trimmed and cleaned. R90 said he could not remember the last time someone trimmed his nails. R90's MDS dated [DATE] said R90 was dependent on staff for personal hygiene care. The facility's policy titled Activities of Daily Living dated 7/20/2024, said Facility ensures that residents receive ADL assistance and maintains resident's comfort, safety, and dignity. The goal is to maximize the residents and staff safely, confidence, independence, and ability to handle everyday activities. 31327 5. On 3/18/25 at 10:39 AM, during initial tour, surveyor went to R19's room. R19 was lying in bed. Her nails in both of her hands were long, yellow, and dirty with a black substance underneath the nail tip. R19 also had strands of hair above her lip and on her chin area. R19 stated, Yes, I want my nails cut. It looks disgusting. I also want to be shaved. The CNA's (Certified Nursing Assistants) don't have time. They are so busy. That's what they say. On 3/19/25 at 10:33 AM, surveyor went back to R19's room. R19 still continued to have long dirty nails and hair on her face. R19 stated, Yup, I still need my face shaved and nails cut. I guess the CNAs are still busy. R19's face sheet shows diagnoses of spinal stenosis, lumbar region without neurogenic claudication, osteoarthritis of hip, other intervertebral disc degeneration, lumbar region with discogenic back pain and lower extremity pain, morbid (severe) obesity due to excess calories, disorder of muscle unspecified, depression, and lack of coordination. R19's MDS (Minimum Data Set) dated 1/22/25 shows she is cognitively intact. R19's care plan dated 1/21/25 shows she has ADL (Activities of Daily Living) self-care performance deficit related to activity intolerance and she requires set up assistance with personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/19/25 at 2:24 PM, V2 (DON-Director of Nursing) stated, The CNAs are responsible for cutting the finger nails and shaving the residents. We have someone from the outside that's within the company who comes and paints and cuts the residents' nails.

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 40054 Based on observation, interview, and record review, the facility failed to monitor a resident's skin for breakdown. This failure resulted in a pressure injury not being identified until it was a stage 3, which delayed treatment, and the wound became infected. The facility also failed to implement pressure ulcer care plan interventions. This applies to 1 of 3 residents (R108) reviewed for pressure injury in a sample of 32. The findings include: On 03/18/2025, observations made at 10:18 AM, 11:01 AM, 12:17 PM, 1:04 PM, and 2:35 PM, showed R108 was visible from his doorway and was lying in bed on his back on a regular mattress. R108 appeared frail and lethargic. The sign on R108's door showed he was on contact and droplet isolation precautions. R108's 3/17/2025 antibiotic care plan showed he was on the antibiotic because of a MRSA (multi-drug resistant organism)/Strep A infection in his wound. On 03/19/2025, observations made at 10:02 AM, 10:58 AM, 12:53 PM, and 2:06 PM again showed R108 lying on his back on a regular mattress. R108's 3/12/2025 Weekly Skin Assessment Tool (effective 10:54 PM) showed R108 had no skin concerns and no new skin issues were noted. R108's 3/17/2025 Wound Assessment Detail report showed his sacral pressure ulcer was a facility-acquired stage 3 pressure ulcer, and it had been identified on 3/13/2025 as a stage 3. The report showed the wound presented with 30% white fibrinous slough, and it measured (in centimeters) 1.5 x 0.5 x 0.1 cm (for length x width x depth). The report showed R108's Braden scale showed he was only at mild risk for skin breakdown. On 3/19/2025 at 3:20 PM, V6 LPN (Licensed Practical Nurse, Wound Care Nurse) measured R108's pressure ulcer. The wound measurements showed the size of R108's sacral ulcer had deteriorated to 1.8 x 0. 9 with an unknown depth due to slough. On 3/18/2025 at 2:00 PM, V6 (LPN- Wound Care Nurse) was asked why R108 was on a regular mattress and why he had not been turned or why pressure had not been offloaded from his wound site. V6 stated R108 did not have a stage 3 pressure ulcer and instead it was a stage 2 pressure ulcer, and a low air-loss mattress was not required. V6 stated positions should be changed as frequently as possible or at least every two hours, and pressure areas should be offloaded. On 03/21/2025 at 9:28 AM, V15 (Nurse Practitioner- Wound Care) said his expectations of the facility are to implement all preventative measures to prevent acquired pressure injuries. V15 stated he recommended using an air-loss mattress, even if a pressure injury is stage 2, shifting weight as frequently as possible but at least every two hours, and offloading pressure areas to prevent facility-acquired pressure injuries. V15 stated regular skin inspections help to identify skin problems earlier in their development. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 03/18/2025 at 2:30 PM, V21 (Certified Nursing Assistant) said they should reposition residents at least every two hours and offload the pressure. V21 stated he elevated R108's head for the meal but then did not change his positions. On 03/20/2025 at 2:50 PM, V2 (Director of Nursing) said she expects nursing staff to check residents' skin daily and follow the facility's skin prevention process of assessing residents' skin and reporting to nurses. V2 said nurses are responsible to assess and contact the physician and initiating wound care immediately. R108's Face Sheet showed his diagnoses include dementia, anemia, and weight loss. R108's 1/6/2025 MDS (Minimum Data Set) showed R108 was severely cognitively impaired and showed he used pressure-reducing devices in bed and was on a turning/repositioning program. R108's 4/22/2024 care plan from admission showed he was incontinent of both bowel and bladder, and he was unable to use a call light for his needs. R108's 3/16/2025 pressure ulcer care plan showed he had a pressure ulcer development related to immobility. Site: Sacrum. Interventions created on 3/16/2025 on this care plan include to avoid positioning the resident on (SPECIFY location), The resident requires the bed as flat as possible to reduce shear, and The resident requires (SPECIFY: Pressure relieving/reducing device) on (SPECIFY: chair.) R108's care plan also showed a 3/16/2025 intervention of follow the facility policies/protocols for the prevention/treatment of skin breakdown. Section 1 of the facility's policy Wound Prevention and Healing policy (revised 06/01/2024) was titled Risk Assessment and Prevention and included guidance for when the Braden Scale should be completed and why, and when skin inspections should be completed. Sections 2-13 (the rest of the policy) showed guidance for wound treatments and did not provide policy guidance or protocols or information for other interventions for wound Prevention, such as when to place specialty mattresses, repositioning to offload pressure, eliminating moisture, or providing assistance with turning because of resident immobility.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944 Based on observation, interview, and record review, the facility failed to provide restorative services to residents with contractures. This applies to 2 out of 3 (R71 and R90) residents reviewed for contractures in a sample of 32. The findings include: 1. On 3/20/2025 at 10:10 AM, R90 said he was unable to extend his fingers on both of his hands. R90's hands were severely contracted, and his hands were in a fixed fist position. R90 said he could not recall the last time he received exercises for his hands. V12 (Restorative Aide) said R90 was to be receiving PROM exercises daily. V12 was asked to open R90's hands. When V12 attempted to perform PROM to R90's hands, she was unable to due to his contractures. When V12 checked his hands, R90's fingernails were so long that they caused indentations to the palm of his hand. R90's palms also had brown substances with a foul odor. R90's Mobility assessment dated [DATE] said R90 had full flexion and extension of his fingers to both hands. R90's 10/21/2024 care plan had a restorative program for PROM daily exercises to both his hands, fingers, and wrist to maintain his current level of range of motion. R90's Mobility assessment dated [DATE] said R90 now had poor flexion and extension to his fingers to both hands. 2. On 3/20/2025 at 10:00 AM, R71 said he had a stroke, and the left side of his body was very weak. R71 said he was unable to use his left arm and hand because they were stiff. R71 said he used to receive exercises on his left arm but no longer. R71's left arm was in a fixed straight position, and he was unable to flex it. R71's left hand was also contracted, and his hand was in a fixed fist position. V12 (Restorative Aide) said R71 was to be receiving PROM (passive range of motion) exercises daily. V12 was asked to demonstrate R71's range of motion, V12 attempted to perform PROM to R71's left arm and hand and she was unable to due to the severity of his contractures. When V12 checked his hand, R71's fingernails were long, unkept, and had a brown substance underneath them. R71's fingernails had caused indentations on the palm of his hand. R71's palm also had a buildup of brown substance with a foul odor. R71 said he wanted to receive exercises to his left arm and hand to be able to assist in his care. R71's care plan had a restorative program for PROM daily exercises to his left upper and lower extremities to maintain his current level of range of motion initiated on 11/14/2022. R71's Mobility assessment dated [DATE] said R71 had poor flexion and extension to his left wrist, fingers, elbow, and shoulder. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/2025 at 10:15 AM, V12 (Restorative Aide) said residents with restorative programs should be receiving their exercises as per their plan of care. V12 said she was unable to do PROM on all residents because she was also responsible for assisting on the units as a CNA (Certified Nurse Assistant). V12 said CNAs were expected to perform PROM exercises and only document them when completed. V12 said it did not appear R71 and R90 had been receiving their PROM exercises. V12 said they did not provide contracture prevention devices, including hand rolls. The facility's policy titled Restorative Nursing Program dated 8/18/2024, said It is the policy of the facility to assist each Resident to attain and or maintain their individual highest most practicable functional level of independence and well-being, in accordance to State and Federal Regulations.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46380 Based on observation, interview, and record review, the facility failed to provide supervision for smokers, and failed to properly assess residents for safe smoking. This applies to 5 out of 5 (R28, R50, R75, R95, R116) residents reviewed for safe smoking in the sample of 32. The findings include: 1. R50 is a [AGE] year-old resident admitted on [DATE]. On 3/18/25 at 9:57 AM, a cigarette burn was noted on resident's wheelchair cushion. R50 said she smokes regularly. On 3/20/25 at 8:40 AM, R50 was observed smoking in the patio. There was no staff supervising the smokers. On 3/20/25 at 12:04 PM, V14 (SSD-Social Services Director) said she was not aware of R50 having a cigarette burn on her wheelchair cushion. She said if she knew that, she would have re-assessed R50 for safe smoking. R50's Smoking Risk Assessment was done on 1/31/24 and 7/16/24 only. Assessment done on 7/16/24 documents that there are no concerns with R50 being careless with smoking materials. 2. R75 is a [AGE] year-old resident admitted on [DATE]. On 3/20/25 at 8:40 AM, R75 was seen in the patio smoking. R75 was observed passing a lit, almost consumed cigarette to R13. There was no staff supervising the smokers. On 3/20/25 at 12:04 PM, V14 said she is unaware that R75 shares his used cigarettes with a peer. R75's Smoking Risk Assessment was done on 8/23/24 and 2/18/25 only. Assessment done on 2/18/25 documents R75 has no problem providing smoking materials to others. 3. R95 is a [AGE] year-old resident admitted on [DATE]. On 3/20/25 at 8:40 AM, R95 was observed smoking in the patio. Review of R95's Smoking Risk Assessment shows it was done on 1/30/23, 1/31/24, 5/9/24 and 6/25/24 only. 4. R116 is a [AGE] year-old resident admitted to facility on 4/2/24. On 3/20/25 at 8:40 AM, R116 was observed smoking in the patio without supervision. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R116's Smoking Risk Assessment shows it was done on 6/21/24, 9/16/24 and 2/11/25 only. Review of R116's care plan does not indicate that he can smoke unsupervised. On 3/20/25 at 12:04 PM, V14 said that smoking assessments should be done upon admission, quarterly and as needed. She said that if a resident needs supervision during smoking, a CNA (Certified Nurse Assistant) or an Activity Aid goes with smokers. She said it is important for smokers to be supervised in case of accidents like burning self or equipment. Facility's Policy on Smoking Residents dated 10/09/21 and reviewed 4/18/24 documents the following: Policy Statement: This facility shall establish and maintain safe resident smoking practices. Policy Interpretation and Implementation. 8. A resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff . 40054 5. A review of R28's EMR (Electronic Medical Record) showed R28 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including traumatic brain injury, repeated falls, schizophrenia, depression, bipolar and anxiety disorder, and substance dependency. R28's MDS (Minimal Data Set) dated 01/10/2025 showed R28 is moderately cognitively impaired and required supervision for activities of daily living. R28 was not assessed for smoking after the admission assessment on 10/21/2024 until 03/18/2025. An updated smoking care plan during the survey on 03/18/2025 by V14 (Social Service Director) showed R28 is to be observed and supervised for smoking-related non-compliant behavior. 03/18/25 11:41 AM: R28 said his family used to bring cigarettes for him, and now he [NAME] cigarettes from his friends. On 03/18/25 2:00 PM, observed R28 going towards the dining room on the first floor and said he wanted a cigarette from a friend to smoke later. R28 looked around and opened the door outside and went out to the smoking area and picked up cigarette butts and put them in his pocket. R28 refused to talk and surveyor reported this to V11 (Nurse), and R28 confirmed that he picked up the cigarette butts to smoke later. On 03/19/2025, around 8:20 AM, R28 picked up a cigarette butt and smoked it. There was no staff supervision/monitoring of residents during the smoking time.

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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. 48944 Based on observation, interview, and record review, the facility failed to provide catheter care to residents. This applies to 2 out of 2 (R90, R54) residents reviewed for urinary care in a sample of 32. The findings include: 1. On 3/19/2025 at 9:50 AM, V7 (Certified Nurse Assistant/CNA) said she was going to provide incontinence care to R54. R54 had an indwelling urinary catheter. R54's incontinence brief was soiled with a large liquid bowel movement. V7 cleaned R54's perineal and buttock area from front to back. V7 then applied a clean incontinence brief. V7 did not provide R54 with catheter care after having an incontinence episode of bowel. R54's indwelling urinary catheter care plan said R54 was to be provided with catheter care during routine peri care. 2. On 3/20/2025 at 10:30 AM, V11 (Registered Nurse/RN) said she was going to provide catheter care to R90. R90 had an indwelling urinary catheter. V11 said R90 recently was treated for a urinary tract infection. V11 proceeded to clean R90's catheter, wiping the tubing in repeated downward and upward strokes using the same wipe. V11 then used another wipe to clean R90's penis foreskin and then the tip and catheter tubing. V11 said catheter care should be provided as needed when soiled and every shift to prevent infections. On 3/20/2025 at 12:25 PM, V2 (Director of Nursing/DON) said she expected the nursing staff to provide incontinence care and catheter care as per the facility's policy. The facility's policy titled Perineal Care/Indwelling Catheter dated 4/18/2024, said Perineal care is provided to clean the perineum, prevent infection, and odors, and provide comfort. 1. Perineal care is done daily and prn for all residents requiring assistance and/ or those residents with a Foley catheter .Ensure Foley catheter is positioned correctly and secured. Wipe down tubing using downward stroke and clean cloth.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31327 Based on observation, interview, and record review, the facility failed to clean and empty a resident's ostomy bag. This applies to 1 of 1 resident (R19) reviewed for ostomies in a sample of 32. The findings include: On 3/18/25 at 10:39 AM, during initial tour, R19 was in her lying in bed. Her ostomy bag was almost full. She stated, It's always full and it needs to be changed it takes a long time for them (staff) to change it. On 3/19/25 at 10:33 AM, R19 was in bed. R19's ostomy bag was still all the way full. R19 stated, They still haven't changed it. They didn't change it at all yesterday and still have not changed it today. I don't know what's going on. On 3/19/25 at 1:02 PM, V3 (Regional Nurse Consultant) stated, (R19) actually has a fistula. She has a lot of fluid in her stomach. (R19) has a history of cancer in her colon. We don't have a care plan for the ostomy. We are making it now. On 3/19/25 at 2:24 PM, V2 (DON-Director of Nursing) stated, (R19) has a fistula, but it is an ostomy bag. If it is 1/3 or more full, the nurse must empty it out or as needed. R19's face sheet shows diagnoses of presence of urogenital implants, personal history of other malignant neoplasm of large intestine and personal history of other diseases of the digestive system. R19's March POS (Physician Order Sheet) shows an order for Change colostomy pouch/appliance every day shift every 3 days. R19's MDS (Minimum Data Set) dated 1/22/25 she is cognitively intact. Review of R19's care plans show there was no care plan for the ostomy or fistula. R19's progress notes document the following: On 1/17/25 at 5:38 AM (Admission Note)-(R19) admitted on [DATE]. (R19) has a foley catheter and urine output was 500 CC. Colostomy bag intact. On 1/20/25 at 3:53 PM (Nurse Practitioner Note)-(R19) is a [AGE] year old female with a history of colon cancer s/p right hemicolectomy. Patient was at hospital 5/20/24 and found to have cecal adenocarcinoma s/p right hemicolectomy c/b abdominal abscess s/p drainage, concern for fistula. Facility's policy titled Colostomy/Ileostomy Care and Management (6/1/24) shows: 1. Pouching system should be changed every 4 to 7 days, depending on the patient and type of pouch 4. Encourage the patient/resident to empty the pouch when it is one-quarter to one half full of urine, gas, or feces .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 48944 Based on observation, interview, and record review, the facility failed to administer tube feedings and care for enteral tubes as ordered for residents with gastrostomy tubes (g-tubes). This applies to 2 out of 3 (R117 and R5) residents reviewed for gastrostomy tubes in a sample of 32. The findings include: 1. On 3/18/2025 at 3:55 PM, V8 (Registered Nurse/RN) said she reviewed R5's gastrostomy tube (g-tube) feeding order. V8 said she was going to initiate R5's scheduled feeding infusion via a pump as ordered. V8 flushed R5's tube with 30 ml (milliliters) of water and then connected the feeding tubing to R5's g-tube. V8 did not check for placement or residual as ordered. V8 then programmed the feeding pump to infuse at a rate of 100 ml per hour. R5's Order Summary Report dated 3/19/2025 showed an order of Enteral Feed Order one time day related to UNSPECIFIED PROTEIN-CALORIE MALNUTRITION Enteral feeding: formula Osmolite 1.5 amount 1980 ml rate 110 ml/hr x 18 hours. R5's report also had enteral feed orders of every evening shift PRIOR TO INITATING FEEDING; ASPIRATE GASTRIC CONTENT, MEASURE AND RECORD and Check for placement prior to medication, flush, or feeding administration: Aspirate Residual feeding if more than 60 ml Notify physician if no aspirate is obtained, check for placement using auscultation. If unable to aspirate or very auscultate, hold administration of medication, flush or feeding and notify MD. 2. On 3/18/2025 at 4:10 PM, V8 said R117 received scheduled g-tube feedings and tube care as ordered. V8 was asked to assess R117's tube site. R117 did not have a dressing and the insertion site had brownish dry buildup drainage. V8 said R117 should have a dressing to her tube site. R117's Order Summary report dated 3/19/2025 showed enteral feed orders of every day shift Cleanse insertion site daily with soap and water during routine care and Cover peri-wound with gauze daily, Observe the peristomal skin for redness, irritation or gastric leakage. On 3/20/2025 at 12:35 PM, V2 (Director of Nursing) said V2 expects nurses to verify enteral feeding orders and infuse feedings as prescribed. V2 also said she expects nurses to verify for g-tube placement prior to starting g-tube feedings and provide site care as per the facility's policy to ensure proper enteral services are provided. The facility's policy titled Gastronomy/Jejunostomy Tube Care and Maintenance dated 5/15/2024, said Daily care of the gastrostomy/jejunostomy tube and exit site will extend the life of the tube, prevent peristomal skin irritation, and assure appropriate hygiene of the tube exit site .4. Clean the tube site daily .5. Observe the peristomal skin for redness, irritation, or gastric leakage .8. Dressings are not necessary unless ordered by MD/NP as indicated .11. Placement should be verified prior to initiation of tube feeding .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 46380 Based on observation, interview and record review, the facility failed to administer medications as ordered. There were 30 opportunities with 2 errors resulting in a 6.6% error rate. This applies to 2 of 3 (R134, R342) residents observed in the medication pass. Findings include: 1. On 3/20/25 at 8:22 AM, during medication administration, V9 (RN-Registered Nurse) administered Ferrous sulfate 325 mg (milligram) to R134. Review of R134's POS (Physician Order Sheet) and MAR (Medication Administration Record) showed the Ferrous Sulfate tablet 325 mg, one time a day is on hold from 3/14/25 to 4/1/25. 2. On 3/20/25 at 9:10 AM, during medication administration, V13 (LPN-Licensed Practical Nurse) did not administer R342's Amiodarone Hydrochloride 200 mg. Review of R342's MAR and POS shows an order for Amiodarone Hydrochloride 200 mg, give one tablet orally in the morning. On 3/20/25 at 11:47 AM, V2 (Director of Nursing) said while passing medications, she expects nurses to follow physician's orders to make sure the right medication is given to the right person and that the five R's (right drug, right dose, right route, right time and right patient) is followed. Facility's Medication Administration Policy dated 3/20/20 and reviewed on 4/18/2024 documents Intent for all medications to be administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 31327 Based on observation, interview, and record review, the facility failed to obtain physician orders for medications brought from home and failed to secure resident medications in a locked compartment. This applies to 4 of 4 residents (R54, R78, R86, R195) reviewed for medications in a sample of 32. The findings include: 1. On 3/18/25 at 10:32 AM, R195 was not in her room. On her windowsill, she had a bottle of regular strength Tylenol 325 MG (Milligrams). On her shelf, she had a tube of Icy-Hot pain relief balm and bottle of Sooth (Bismuth subsalicylate) 525 MG. On 3/19/25 at 10:36 AM, surveyor went back to R195's room. The medications were still in her room. Surveyor asked R195 about the medications, but she was unable to speak English because her primary language was Spanish. R195's face sheet shows diagnoses of depression, lack of coordination, other specified disorders of muscle, and bilateral primary osteoarthritis of knee. Review of R195's March POS (Physician Order Sheet) shows no orders for the medications. R195's MDS (Minimum Data Set) dated 1/4/25 shows a BIMS (Brief Interview for Mental Status) score of 14 which means she is cognitively intact. On 3/19/25 at 2:24 PM, V2 (DON-Director of Nursing) stated, Nurses need an order from the physician if residents and/or their families bring medications from home or the store. If there is an order for the medications to be at the bedside, then it should be locked up in the nurse's medication cart. Nurses shouldn't leave medications in the resident's room. 46380 2. On 3/18/25 at 10:07 AM, several boxes of unlabeled medication were found in R78's room. She had a big container of Cranberry tablets, she said she takes two tablets a day. She had a small box of Gas-X, Fexofenadine Hydrochloride, Phenylephrine Hydrochloride 10 mg (milligram) and a bottle of Melatonin 5 mg. All medications were unlabeled. R78 said her friend brought it over. She said she likes her medication close to her so she can take it when she needs it. On 3/18/2025 at 2:00 PM, review of R78's POS did not show any order for Cranberry tablets, Gas-X, Fexofenadine Hydrochloride and Phenylephrine Hydrochloride 10 mg. Furthermore, there was no order for medication to stay at bedside and for her to self-administer medication. R78 had an order for Melatonin 5 mg. R78's MAR (Medication Administration Record) for March reviewed, R78 receives Melatonin 5 mg every night at 9:00 PM. Resident refused to take Melatonin on 3/7/25. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	48944 3. On 3/18/2025 at 9:55 AM, R86 was in bed. R86 had a box filled with Salonpas (pain relief) patches on her bedside table. R86's Order Summary Report dated 3/20/2025 did not show an active order for Salonpas pain patches. 4. On 3/18/2025 at 10:30 AM, R54 was in bed. R54 had a bottle filled with Nystatin powder (antifungal) on her bedside table. R54's Order Summary Report dated 3/20/2025 did not show an active order for Nystatin antifungal powder. The facility's policy titled Medication Storage in the Facility dated 11/2021 said Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 48944 Based on observation, interview, and record review, the facility failed to serve a resident his prescribed diet. This applies to 1 out of 3 (R71) residents reviewed for diets in a sample of 32. The findings include: On 3/18/2025 at 12:40 PM, R71 was in an upright bed in a slouched position with his hips below the bend of the bed. R71 was not properly positioned in bed. R71 was eating his served lunch meal that had a yellow drink that was thin in consistency. R71's meal ticket indicated he was to receive nectar-thickened liquids. V9 (Agency Registered Nurse/RN) was asked to check R71's served drink and V9 verified R71 was not served the correct consistency of drink. On 3/20/2025 at 12:25 PM, V2 (Director of Nursing/DON) said she expects nursing staff to check residents' meal tray items and tickets prior to serving them their meals to ensure they are receiving their prescribed diet. R71's Order Summary Report dated 3/20/2025 showed his diet was General diet, Regular texture, Nectar consistency initiated on 3/04/2025. R71's care plan said he had a swallowing problem related to dysphagia and was to receive nectar-thickened liquids. R71's interventions included Diet to be followed as prescribed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on observation, interview and record review the facility failed to maintain the kitchen facility in a manner to prevent foodborne illness. This applies to 132 residents in the facility receiving dietary services. Findings include: On [DATE] at 11:29 AM, V3 Regional Nurse Consultant confirmed 132 residents were being served from dietary services on [DATE]. 1. On [DATE] at 10:28 AM, V16 Dietary Manager stated the dishwasher disinfects by temperature. The dishwasher needs to reach 180 degrees to disinfect the dishes. V16 ran the dishwasher twice. The wash cycle gauge max temperature was 142 degrees Fahrenheit. The rinse cycle gauge max temperature was 154 degrees Fahrenheit. The final rinse cycle gauge max temperature was 150 degrees. The test strip used for the test cycle reached 160 degrees Fahrenheit. On [DATE] at 10:49 AM, V18 Dietary Aide stated when she has logged the temperature for the dishwasher, she used the black and white strips circles. V18 stated the dishwasher needs to reach 185 degrees to disinfect the dishes. The dishwasher temperatures are logged. On [DATE] at 10:51 AM, V19 Dietary Aide stated she primarily does the dishwasher temperature log. V19 stated she had done the log earlier. V19 stated the dishwasher needs to reach 180 degrees to disinfect the dishes. V19 stated the facility uses the black strips and white strips with circles. V19 stated she writes the temperature from the gauges on the log not the test strips. The test strips are used as a back up to verify the correct temperature has been reached. V19 was asked to run the dishwasher again as she normally does. The wash cycle gauge max temperature was 172 degrees Fahrenheit. The rinse cycle gauge max temperature was 174 degrees Fahrenheit. The final rinse cycle gauge max temperature was 160 degrees. The test strip used for the test cycle reached 160 degrees Fahrenheit. The facility did not provide a dishwasher policy. In the dishwashing area a fan was on and aimed towards where washed dishes come out of dishwasher. The fan was covered with grease and blowing strands of dust and hair on the fan grill. The fan had pieces of paper and candy wrapper stuck to it and inside of the fan. On [DATE] at 01:36 PM, V24 Regional Dietary Director stated he was not aware of any issues with the dishwasher. He was told the strips being used were expired. The reading from the strips and the temperature gauge should match. Kitchen staff should be reading both the gauge and the strips. If neither the strip nor gauge reached the required 180 degrees a work order should have been sent out for the dishwasher to be repaired. The dishes are disinfected at 180 degrees. If the residents are served from dishes and 180 degrees was not attained there is a potential to expose them to foodborne illness. (continued on next page)

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	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Orchard Valley	2330 West Galena Boulevard Aurora, IL 60506

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