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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145657	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pearl of Downers Grove	3450 Saratoga Avenue Downers Grove, IL 60515

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to identify, assess, and initiate treatment orders for an acquired pressure injury upon identification. This failure resulted in R3 developing an unstageable left ischium pressure ulcer. This applies to 1 of 7 residents (R3) reviewed unstageable for pressure ulcers The findings include: R3's face sheet shows he was admitted to the facility on [DATE] with diagnoses including quadriplegia, personal history of traumatic brain injury, encounter for attention to gastrostomy, epilepsy and neuromuscular dysfunction of bladder. R3'S Braden Scale assessment dated [DATE] shows he was at moderate risk for developing pressure. R3's Braden Scale assessment shows on 10/24/25 he was a HIGH RISK for developing pressure. R3's EHR (Electronic Health Records) shows he had a facility acquired stage 2 ischium pressure ulcer identified on 9/10/25 and healed on 9/23/25. R3'S Physician Order Sheets dated through January 2026 shows orders dated 9/10/25 for wedge cushion and low air loss mattress. The P.O.S. shows he was admitted to hospice in June 2025. R3's Wound Notes by V4 (Wound Nurse) dated 12/18/25 shows left ischium deep tissue injury measuring 12 cm (centimeters) x 9.0 cm), deep [NAME] 70%, blood filled blister 30%, moderate amount of serosanguineous drainage. Peri wound criteria: erythema, maceration, bogginess. On 1/21/26 at 2:40 PM, V9 (Nurse Practitioner-Wound) said R3 had multiple risk factors for developing wounds. R3 was totally dependent on staff for all cares and had a history of wounds prior that healed. Sometimes the wounds can progressively get worse if the area is not off-loaded and not repositioned frequently. If they were assessing R3's skin it should have been non-blanchable prior to the skin being deep maroon. It's not unusual for a deep tissue injury to open because of the necrotic tissue in the wound. R3's deep tissue injury opened to an unstageable left ischium pressure wound. On 1/22/26 at 8:02 AM, V7 (Registered Nurse-RN) said R3 is non-verbal, totally dependent on staff for all cares including bed mobility. On 12/17/25 she was R3's night nurse. It was reported to her by the aide, R3 had a wound on his bottom. It was reported R3's ischium was red and bleeding. V7 said she did not assess the wound or document in the resident's medical record the wound. She notified V4 (Wound Nurse) in the morning about R3's wound. Usually, we report the wounds to the wound nurse, and she will assess the wound. On 1/21/26 at 10:28 AM, V4 (Wound Nurse) said any new wounds should be reported to me. She takes pictures of the wound, assesses the wound, notifies the physician and family, and obtains treatment orders. On 12/18/25, she was notified about R3's left ischium wound by the aide. R3 had a large deep tissue injury measuring 12cm x 9cm, it was bad when she assessed the wound. There was no dressing on his ischium. It seemed strange there was no wound on 12/16/25 when V8 (Wound Nurse) said she checked his skin. It seems like a very small amount of time for the wound to get that bad. The wound should have been identified prior to it being a large maroon area on his ischium. She confirmed nursing did not report the wound to her; and the aide notified her. R3 is totally dependent on staff, non-verbal resident, he is a quadriplegic from a motorcycle accident a year ago. R3 was at great risk for developing pressure to that area, he had a (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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	previous healed wound to the ischium, preferred to lay on his left side. He was dependent on staff for repositioning, he had a wedge and would wiggle off the wedge. R3 had a healed pressure ulcer to the same area and was followed by the wound care team. He should have had a protection dressing in place to that area. On 1/21/26 at 2:06 PM, V8 (Wound Nurse) said R3's wound re-opened to his left ischium, it started as a deep tissue injury then opened. R3 was being followed by wound care prior to the wound developing. R3 should have had a protective dressing in place prior to the wound re-developing. V8 said she was providing R3's wound treatments and did not see the wound prior to it being found at 12 cm x 9cm deep maroon pressure. V8 said she assessed R3's skin last on 12/13/25 and he did not have a wound to his ischium and confirmed she did not assess R3's skin on 12/16/25. V8 stated, wounds can appear overnight sometimes. On 1/21/26 at 1:30 PM, V6 (Certified Nursing Assistant-CNA) said she was R3's regular aide. R3 was non-verbal, transferred using the mechanical lift, he would wiggle maybe his arms, but was not able to scoot his lower body or legs. On 12/18/25, on day shift, R3 had a dark spot on his ischium and there was no dressing to that area. The previous shift reported the wound and there was never a dressing in place prior to that. If there is new wound, staff should report it to the nurse right away. On 1/23/26 at 9:48 AM, V15 (Wound CNA) said she rounds with the wound nurses. She last rounded with V8 on 12/13/25 and said R3 did not have a wound to his ischium. She was confused how the new wound was so big. She said V8 would apply a protective dressing to R3's lower left back, but not where the new wound was. After the new wound was found we were making sure R3 was repositioned more frequently. R3 favored his left side and could not roll from side to side on his own. On 1/21/26 at 11:26 AM, V2 (DON) said he was investigating how R3 re-developed the left ischium wound. It's hard to figure out. R3 is dependent on staff for all cares. He had a history of skin breakdown, and was high risk due to his co-morbidities. He tended to lay on his left side. V7 (RN) reported she was notified of R3's wound by the aide and documented the wound. V4 (Wound Nurse) said she did not notice any wounds to R3's ischium prior to when it was identified. Any new wounds should be assessed, reported to the physician/family, obtain treatment orders, and documented. On 1/23/26 at 1:30 PM, V2 said he did not know V7 did not document R3's wound in the electronic medical record and confirmed it should have been identified prior. R3's EHR shows there was no documentation of the left ischial pressure on 12/17/25. V3's Wound Progress Note dated 12/24/25 shows he was seen for initial wound evaluation. Left Ischial is a deep tissue injury persistent with non-blanchable deep red, maroon, or purple discoloration pressure ulcer. Wound measurements 14 cm x 9cm x 0.1cm. V3's Wound Progress Note dated 1/7/26 shows his Left Ischial is an unstageable pressure injury with full thickness skin and tissue loss. Wound measurements 9cm x 8.5cm x 1.1cm. R3's current care plan shows he has the potential for impairment to the skin and developed a pressure wound to his left ischium with interventions including assist with turning and repositioning frequently, barrier cream to areas exposed, identify/document potential causative factors, low air loss mattress, wedge pillow, notify nurse immediately of any new skin areas of skin breakdown, report changes in skin status to physician. The facility's Treatment/Services to prevent/Heal Pressure Injuries and other wounds policies dated 1/21 states, It is the policy of this facility to ensure it identifies and provides needed care and services that are resident centered.a resident receives care.to prevent pressure injuries and doe not develop pressure injuries unless the individual's clinical condition demonstrates unavoidable.interventions will be implemented in the resident's plan of care to prevent injury development.

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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, and record review the facility to provide care and services and failed to maintain the catheter below the level of the bladder for a resident with an indwelling urinary catheter. This applies to 1 of 3 residents (R1) reviewed for indwelling catheters in the sample of 7. The findings include: R1's face sheets shows he was admitted to the facility on [DATE], with diagnoses including obstructive and reflux uropathy, atrial fibrillation, congested heart failure, paralytic ileus, alcoholic cirrhosis liver, polyneuropathy, benign prostatic hyperplasia without urinary tract symptoms, anxiety, major depressive disorder, and COPD. On 01/16/26 at 10:30 AM, R1 was observed lying in his bed and his indwelling catheter bag hanging on the top drawer handle of his bedside table. The drainage tubing was positioned pulling back to the right side and not positioned below the level of the bladder. R1's anchored device was folded around the tubing not secured to his leg. R1 said he has tearing to his penis (from previous facility) because the staff were not using the anchored device, not emptying his drainage bag and the weight of the bag would pull on his penis. R1 said he reported to the staff he needed a new anchoring device yesterday but they did nothing. On 1/16/26 at 11:06 AM, V5 (Licensed Practical Nurse-LPN) said R1 has a catheter and is followed by a urologist and she is not sure who changes his catheter when needed. She confirmed R1 has a penile tear, due to poor hygiene. I don't think V4 (Wound Nurse) does anything for it. V5 said she has not observed the area this morning and his drainage bag was full 1600 cc of urine was emptied this morning. Staff should empty the drainage bag every shift and as needed. On 1/16/26 at 11:15 AM, V5 entered R1's room and questioned why the drainage bag was hooked on the top of drawer handle of the bedside table. She lifted the drainage bag in a upward position above the level of the bladder and handed the bag to the aide and placed it on the left side. R1 requested for the drainage bag to placed on the right side. V5 said the drainage bag should be positioned below the level of the bladder. V5 said R1 prefers it to be placed on the right side. R1 stated, I never told them to hang it on the drawer. R1's meatal tear was present at the catheter insertion site without the secured device in place. V5 confirmed the secured anchored device was not in place and there should be one in place to prevent pulling. On 1/16/26 at 12:33 PM, V3 (ADON) said catheter care should be done every shift and as needed. Catheter care includes emptying the bag at minimum every shift and as needed, privacy bag, and stat lock in working condition. If the catheter bag is full it can put pressure on the urethral causing pressure and urine back flow to potentially causing bacteria infections. Stat locks are in place for males to ensure pressure or pulling is prevented because it could cause trauma or tearing to the tip of the penis. R1 has told me he has this issue and he explained this is a risk due to chronic catheter use. R1's current care plan shows he has an indwelling catheter with interventions to secure tubing properly to prevent pulling or dislodgement, monitor insertion site and surrounding, keep drainage bag below the level of the bladder at all times. R1's care plan does not include his meatal tear. The facility's Indwelling Urinary Catheter Use Policy states, It is the policy of the facility to ensure appropriate use of indwelling catheters in accordance with State and Federal Regulations .consider a securement device or staff will ensure that catheter tubing is supported .to prevent inadvertent removal or tugging.