			(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					c
		IL6002174	B. WING		02/08/2024
		12002114			02/00/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
PFARI O	F ORCHARD VALLEY	2330 WE	ST GALENA BOU	LEVARD	
		AURORA	A, IL 60506		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
IAG			IAG	DEFICIENCY)	
S 000	Initial Comments		S 000		
	Annual Licensure Sur	rvey			
	Complaint Investigation	on: 2470857/IL169338			
	Complaint investigation	OII. 2470037/1L109330			
00000	Fig. 1 Ob + +		50000		
S9999	Final Observations		S9999		
	Statement of Licensu	re Violations:			
	300.610a)	TE VIOIATIONS.			
	300.1210b)				
	300.1210c)				
	300.1210d)1)3)				
	Section 300.610 Resi	ident Care Policies			
	a) The facility shall h	nave written policies and			
		g all services provided by the			
		olicies and procedures shall			
	be formulated by a Ro				
	Committee consisting				
		visory physician or the nmittee, and representatives			
		services in the facility. The			
		with the Act and this Part.			
		hall be followed in operating			
		pe reviewed at least annually			
	•	cumented by written, signed			
	and dated minutes of	the meeting.			
		neral Requirements for			
	Nursing and Persona				
		ovide the necessary care			
		or maintain the highest			
		mental, and psychological			
	· ·	dent, in accordance with rehensive resident care			
		properly supervised nursing			
		re shall be provided to each			
		otal nursing and personal			
	care needs of the res				
	nent of Public Health				'
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	ιE	TITLE	(X6) DATE

Electronically Signed 02/26/24

STATE FORM 6899 787411 If continuation sheet 1 of 13

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IL6002174	B. WING		C 02/08/2024	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	,	
PFARI O	ORCHARD VALLEY		T GALENA BO	ULEVARD		
1 LAILE OI	OKONAKO VALLET	AURORA,	IL 60506			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLE	TE
S9999	Continued From page	:1	S9999			
	be knowledgeable ab respective resident ca d) Pursuant to subse care shall include, at a and shall be practiced seven-day-a-week ba	ection (a), general nursing a minimum, the following I on a 24-hour,				
	be properly administe 3) Objective ob resident's condition, ir emotional changes, a determining care requ	servations of changes in a nocluding mental and s a means for analyzing and aired and the need for ation and treatment shall be and recorded in the				
	This REQUIREMENT	is not met as evidenced by:				
	review, the facility fail- pain medication for a addition, the facility fa medication that was p failure resulted to R97 severe pain and resul complete activities du session. This applies	n, interview, and record ed to assess and provide resident who is in pain. In illed to reassess if the pain provided was effective. This r and R98 to experience ted in R97's inability to ring her physical therapy to 2 of 3 (R97 and R98) magement in a sample of 29.				
	The findings include:					
	1. Face sheet showed	that R97 has multiple				

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STATE FORM 6899 787411 If continuation sheet 2 of 13

PRINTED: 03/12/2024 FORM APPROVED

Illinois Department of Public Health

AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		IL6002174	B. WING		C 02/08/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E ZIP CODE	
TO UNIC OF T	NOVIDEN ON OUT FEET		ST GALENA BOU		
PEARL O	ORCHARD VALLEY		A, IL 60506	LLVAND	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
S9999	Continued From page	2	S9999		
	the lumbar region, he following cerebral infa	/linimum Data Set (MDS)			
	that she was prescrib mg (milligrams) twice neuropathy, Hydromo tablet every 6 hours a Voltaren Arthritis Pain	opical). Apply to tailbone			
	her Dilaudid as a prn every day at least one most 3 times day for p was given a dose of E she was informed that and the staff would re 1/24/24, prior to physic requested for her Dilaudid re gave her the regular of the neuropathy, Voltaren and Tylenol which did having pain on her left attended physical the want to miss a session Therapist/PT) assisted bike. She was only or when she felt the pair "bawling in pain." The left leg, and tail bone, shooting and sharp par	d her to ride the elliptical n the bike for three minutes n getting worse, she was pain was on her left foot,			

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STATE FORM 6899 787411 If continuation sheet 3 of 13

	OF DEFICIENCIES OF CORRECTION					
		IL6002174	B. WING		02	C / 08/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
DE A DI OI	- 00011400 1/41151/	2330 WE	ST GALENA BOUI	LEVARD		
PEARL O	F ORCHARD VALLEY	AURORA	A, IL 60506			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
S9999	was not available. R9 she wanted her Dilau soon as it was deliver. On 2/6/24 at 3:25 PM Pharmacist) stated the refill order for R97's EPM. It was delivered 9:15 PM. In the bingothere is a recommend staff should call for movement when they see that the remaining, they should upon how often the resultant the staff should composed for 2/07/24 at 9:58 All Pharmacist) stated the medications twice dailevening. The staff should composed for Hydromorph could have gotten it for medication-controlled pharmacy delivery.	it every shift but was told it 7 instructed the staff that did to be given to her as red. , V14 (Registered at the facility staff placed a Dilaudid on 1/24/24 at 2:25 to the facility on 1/24/24 at a card medication container, ded indication of when the edication refill. It shows that ere were only 5 tablets d re-order and/or depending esident takes the medication rall for refill. M, V49 (Registered at the pharmacy delivered ly in the morning and bould order for refill when it is But with regards to R97's one (Dilaudid) the staff rom the electronic box while waiting for the	S9999			
	have been tearful. V2 having severe pain se Typically, R97's tailbo	M, V23 (Physical that on 1/24/24, R97 may 3 recalled that R97 was evere pain on her foot. one hurts. V23 usually calls tell her what time V23 will				
	pick her up, by then F pain medication. Norr have pain aside from but at that time R97 v her left foot. R97 repo for the pain medication	R97 had already taken her mally R97 doesn't really her chronic tailbone pain, was complaining of pain in orted that she was waiting on because it wasn't given to ot want to miss a session of				

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STATE FORM 6899 787411 If continuation sheet 4 of 13

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		IL6002174	B. WING		02	C 2/08/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
DEADL O	F ORCHARD VALLEY	2330 WE	EST GALENA BOUL	_EVARD		
PEARL U	F ORCHARD VALLET	AUROR	A, IL 60506			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S9999	the PT. R97 was very sessions and there we always finished her the could not complete the she was hurting a lot knew that the pain me available because R9. On 2/7/24 at 10:32 A Practitioner/NP) state on top of multiple me Dilaudid should be giordered. V25 offered regular dose with inc R97 refused, stating only as she needed. Dilaudid only works f PT. V25 added that semedication will be averequested it for pain. On 2/7/24 at 11:03 A that R97 has chronic oral Dilaudid and Gapain. If she requested given as ordered. On 2/7/24 at 10:24 A she believed that R9 (Dilaudid) was not ave 2/7/24 at 11:29 AM, Nepain assessment was 0-10, with 10 being the physician order for the effective pain manage.	y cooperative with therapy vas progress in her. R97 herapy, but that day, R97 he recumbent bike because and she couldn't walk. V23 edication (Dilaudid) was not 97 told her. M, V25 (Nurse ed that R97 has chronic pain idical co-morbidities. R97's even for severe pain as to order the Dilaudid as a reased frequency, however, that she wanted to take it R97 has chronic pain, or 3-4 hours, it works during she expects that the ailable to R97 whenever she M, V26 (Physician) stated pain. R97 is on a regimen of bapentin to help manage her d the Dilaudid, it should be M, V24 (Nurse), stated that	S9999	DEFICIENC		
	pain in about half an having pain, then the	also do post assessment of hour. If the resident is still nurse calls the doctor. The ilable on 1/24/24 and V24				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С
		IL6002174	B. WING		02/08/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STAT	E, ZIP CODE	
PEARL O	F ORCHARD VALLEY		ST GALENA BOU	JLEVARD	
	Т		A, IL 60506		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETE
S9999	was upset because the but when V24 informed ordered, R97 became check the electronic of Dilaudid was available should have gone to medication box to get of the first-floor medication-controlled the first-floor medication available 6 tablets of V49 presented a copy Medication Box's Item 1/1/24 through 2/7/24 total of 8 tablets of Hyin the electronic medifacility. R97's Controlled Drug Receipt/Record/Disposition on 1/23/24 at 1 R97's Controlled Drug R97's Con	day. V24 recalled that R97 ne Dilaudid was not available ed R97 that she already e satisfied. V24 did not controlled box to see if the e, she added that she the electronic controlled the Dilaudid. M, surveyor and V49 ist) checked the electronic box which was located on ion room. It showed Dilaudid 2 mg. y of the Electronic Controlled n Transaction Log dated showed that there was a ydromorphone 2 milligrams cation controlled box in the g position form which was shows that R97 took this a day. The last dose was 2:30 PM.	S9999		
	dispensed on 1/24/24 Dilaudid 4 mg on 1/29 The above Controlled	shows that R97 was given 5/24 at 2:30 AM.			
	R97 did not received Physical Therapy Not R97 performed bilate	the Dilaudid for 38 hours. The stated 1/24/24 showed:			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S	
AND FLAN C	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPL	LETED
						C
		IL6002174	B. WING		02/0	08/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PEARL OF	ORCHARD VALLEY	2330 WES	T GALENA BO	ULEVARD		
I LAKE OF	OKONAKO VALLET	AURORA	IL 60506			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From page	e 6	S9999			
\$9999	facilitate increase streindependence with m participates with skille complaint of nerve participates or irritation ambulation (gait trainstates that the nurse the medication to arripresent at the end of would discuss it with notes for 1/19/24 and was able to perform graph received Dilaudical R97's active care planshows: Focus: R97 hand pain related to strein with Ileostomy placent Goal: R97 will not have activities due to pain Interventions: Administer analgesi Give 1/2 hour before Hydromorphone HCI (Hydromorphone HCI (Hydromorphone HCI Acetaminophen Anticipate the R97's respond immediately Identify and record pains and pain relief, side effect Identify, record, and conditions which may discomfort related to	ength to BLE to increase obility. R97 actively ed intervention. R97 ain in the left foot. There was in to the skin. R97 declined ing) due to foot pain. R97 was aware and is waiting for ve to facility. Nurse was the session, stating that she R97. In addition, the PT 1/25/24 shows that R97 gait training (On these days, diaccording from the MAR). In with target date of 3/11/24 as generalized body aches atus post Perforated Colon ment and Crohn's disease. We an interruption in normal through the review date. In a medication as per orders. Treatments or care. Oral Tablet 2 MG In and impact on function. The proposition of the pain and impact on function. The proposition of the pain and impact on function. The proposition of the pain and or stroke. The proposition of the pain and or stroke.	S9999			
	possible Monitor/record/repo symptoms of non-ver	rt to Nurse any sign and bal pain: Changes in				

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STATE FORM 6899 787411 If continuation sheet 7 of 13

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPL	150
		IL6002174	B. WING		02/0	; 8/2024
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 0=-0	<u></u>
		2330 WES	T GALENA BO	ULEVARD		
PEARL O	F ORCHARD VALLEY	AURORA,				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	COMPLETE DATE
S9999	Continued From page	e 7	S9999			
	breathing (noisy, dee	•				
		ons (grunting, moans, yelling				
	,	ehavior (changes, more				
		ressive, squirmy, constant				
	, , ,	ppen/narrow slits/shut,				
		cus); Face (sad, crying,				
		ched teeth, grimacing) Body				
	 (tense, rigid, rocking, curled up, thrashing). - Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. -Report to Nurse any change in usual activity attendance patterns or refusal to attend activities 					
		symptoms or c/o pain or				
	discomfort.	ympteme of the paint of				
	There was no docum	ented comprehensive pain				
		V24 (Nurse) in the progress				
	notes on 1/24/24 and	no documentation of				
	Tylenol in the MAR (N	Medication Administration				
	Record) which indica	te that it was being given.				
	There was no re-asse	essment of the efficacy of				
	Tylenol.					
	2 Nurse practitioner	note, dated 1/31/24, shows				
	•	uded a history of wrist				
	_	post right wrist arthrotomy				
	and washout complet	· ·				
	POS (Physician Orde	er Sheet), printed 2/7/24,				
	shows R98 was admi	itted to the facility on				
		nows R98's diagnoses				
	included synovitis and tenosynovitis right hand,					
		nyelopathy or radiculopathy				
		heral vascular disease, and				
		POS shows R98 had a				
	· •	d 1/22/24) for Norco 10-325				
		let by mouth every 6 hours				
		The POS also shows R98				
		r (dated 1/22/24) for Norco				
	10-325 mg 2 tablets b	by mouth every 6 hours as				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	ON (X3) DATE SURV	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
						С
		IL6002174	B. WING		02/	08/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
DEADL O	CODOLLADO VALLEY	2330 WES	T GALENA BO	ULEVARD		
PEARL O	F ORCHARD VALLEY	AURORA,	IL 60506			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORI	RECTION	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE
S9999	Continued From page	e 8	S9999			
	needed for nain. Nei	ther physician order for				
		neters to indicate when the				
	medications should b					
	Thousand one official b	o given.				
	Pain Assessment. sic	gned 1/22/24, shows R98				
		he described as almost				
	constantly, that frequ					
		that occasionally had effect				
	on his sleep, and alm	ost constantly interfered				
	with his therapy activities. R98 described his worst pain in the prior five days as a 0 out of 10					
		ain and ten being the worst				
	·	e. R98 stated his most				
	recent pain was a 9 c	out of 10.				
	MD0 (M: : D (0 1) 1 1 1 10/10/00 1				
		Set), dated 12/10/23, shows				
	R98's cognitive status	s was intact.				
	On 2/5/24 at 11:18 Al	M, R98 was rubbing his right				
		as been rough." R98 stated				
		as in much pain. R98 stated				
		prescribed pain medications,				
		eving the pain in his right				
	hand. R98 described	his current right wrist pain				
	as 8 on a scale of 10	with 10 being excruciating				
	pain. R98 stated he	received his medication				
	earlier that morning, I					
		medication was effective.				
		iving his prescribed pain				
	-	in his right wrist was only				
		n a scale of 10. R98 stated				
	I	elieved to a 0 out of 10. R98				
		ider his right wrist pain as				
		vel was reduced to a 3 or 4				
	out of 10. R98 stated					
		iving the same dose of his which was better relieving				
	•	he was currently receiving				
		urs and his pain was much				
		stated he had not yet seen a				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	IED
					c	
		IL6002174	B. WING		02/0	8/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DEADL OF	ODCHADD VALLEY	2330 WEST	GALENA BO	ULEVARD		
PEARL OF	F ORCHARD VALLEY	AURORA, I	L 60506			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
\$9999	physician or nurse presince he had been ad stated he had asked I Norco dose to every for "When the doctor constated his physician of was supposed to see had not yet seen one admitted. R98 stated uncomfortable due to On 2/5/24 at 11:52 AI V44 (Registered Nursask for 2 [pain pills] - zero." R98 stated show medication that morninot yet asked him if it had been busy. R98 her his pain was never and asked V44 to ask change his scheduled four hours instead of scheduled in the hosp	actitioner/physician assistant Imitted to the facility. R98 his nurse to change his four hours, but was told, nes, we will ask." R98 or physician representative him once a week, but R98 of them since he was he had been very his right wrist pain. M in R98's room with R98, se) stated R98 "will really he says it helps. He says	S9999			
	2/1/24 to 2/29/24, sho included Norco oral ta 2 tablets every six ho	ministration Record), dated bws R98's pain medication ablet 10-325 mg (milligrams) urs as needed which was				
	measurement of pain administration of R98 administration was re effective. The MAR s Norco 2 tablets on: 2/1/24 at 11:58 AM fo	r a pain level of 9 and umerical measurement of				

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	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU N OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLET					
		IL6002174	B. WING		02	C 2/08/2024
	ROVIDER OR SUPPLIER F ORCHARD VALLEY	2330 W	ADDRESS, CITY, STATE EST GALENA BOUI A, IL 60506			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
\$9999	marked "E" with no n pain. 2/2/24 at 6:14 AM for marked "E" with no n pain. 2/3/24 at 10:28 AM for marked "E" with no n pain. 2/3/24 at 7:40 PM for marked "E" with no n pain. 2/4/24 at 8:26 AM for marked "E" with no n pain. 2/4/24 at 8:26 AM for marked "E" with no n pain. 2/5/24 at 9:43 AM for marked "E" with no n pain. MAR, dated 2/1/2024 order (dated 1/22/24) shift every shift for pawas recorded to have shift from 2/1/2024 to shift 2/2/24 (2 out of administration of pair see if the pain medicareviewed R98's MAR showing R98 describ and stated R98 was management. On 2/07/24 at 12:29 In the did not recall facility R98's pain level num had a history of difficition.	umerical measurement of a pain level of 10 and umerical measurement of or a pain level of 8 and umerical measurement of a pain level of 7 and umerical measurement of a pain level of 8 and umerical measurement of a pain level of 8 and umerical measurement of a pain level of 8 and umerical measurement of a pain level of 8 and umerical measurement of a pain level of 8 and umerical measurement of a pain level of 5 and umerical measurement of a pain level of 8 and umerical measurement of a pain level of 8 and umerical measurement of a pain level of 8 and umerical measurement of a pain level of 8 and umerical measurement of	S9999			

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SUI COMPLET	
					С	
		IL6002174	B. WING		02/08	/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PEARL O	F ORCHARD VALLEY	2330 WES	T GALENA BO	ULEVARD		
		AURORA,	IL 60506			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
S9999	Continued From page gabapentin to avoid b for R98. V43 stated F during R98's recent h management was from the facility had called was not effectively relevated alternative partorelieve R98 of pain not effective. V43 states in pain." Pain care plan provide 2/8/24 and revised on generalized body ach depression and diabe plan fails to show R98 right hand. Intervention "Monitor/record/report complaints of pain or Notify physician if interventions fail to show R98 for the effectiven after administration. Facility Pain Manager reviewed 12/17/23, shorovide adequate pair management so that the highest practicable.	e 11 clood pressure complications R98 lived in chronic pain and cospitalization, R98's pain int and center. V43 stated if him to report R98's pain ieved, he would have ain management treatments if his current regime was ited, "I don't want people to ed by V1 (Administrator) on in 1/26/24, shows R98 had es and pain related to tic neuropathy. The care is has pain associated with is cons include it to nurse resident requests for pain treatment. erventions are unsuccessful it is a significant change from ence of pain." The now nursing was to reassess ess of his pain medication ment policy/procedure, nows, "The facility will	S9999			
	scheduled assessmer condition or status (e. in behavior or mental signs and symptoms	ide but are not limited to:				

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					_ ا	
		B MINC		C		
		IL6002174	B. WING		02/08	8/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
PEARL OF ORCHARD VALLEY						
AURORA, IL 60506						
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOUL			COMPLETE
TAG			TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DEFICIENCY)		
S9999	Continued From page	. 12	S9999			
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	Assessment and evaluation by the appropriate					
	members of the interdisciplinary team may					
	include: a. Asking the patient to rate the intensity					
	of his/her pain using a numerical scale or a verbal or visual descriptor that is appropriate and					
	preferred by the resident c. Identifying key					
	characteristics of the pain (Examples: Duration,					
	Frequency, Location, Onset, Pattern, and					
	Radiation) d. Obtaining descriptors of the pain					
	(Examples: Aching, Burning, Throbbing, Tingling,					
	Stabbing), e. Determining factors that make the					
	pain better or worse, f. Identifying recent					
	exacerbations of chronic pain, g. Impact of pain					
on quality of life j. The resident's goals for						
	pain management and his/her satisfaction with					
the current level of pain control. k. The						
effectiveness of specific drugs and other						
· · · · · · · · · · · · · · · · · · ·						
	treatments used in the past to treat pain. 4. IF					
	the resident's pain is not controlled by the current					
	treatment regimen, the practitioner should be					
	notified. 5. The interdisciplinary team and the					
	resident collaborate to arrive at pertinent,					
	realistic, and measurable goals for treatment					
	9. The interdisciplinary team is responsible for developing a pain management regimen 11. Reassess patients with pain regularly based on the facility's established intervals. 12. If when re-evaluated, findings indicate pain is not adequately controlled, revise the pain					
	management regimen and plan of care as					
	indicated."					
	"B"					

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