STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002174	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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)5) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999		

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S9999	Continued From page 1 care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These requirements are not met as evidenced by: 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	S9999		

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S9999	Continued From page 2	S9999		

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

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S9999	Continued From page 3	S9999		

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.

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

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S9999	Continued From page 4 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. (B)	S9999		