STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PEARL OF ORCHARD VALLEY	2330 WEST GALENA BOULEVARD AURORA, IL 60506

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S 000	Initial Comments Complaint Investigations: 2377767/IL164510 2377719/IL164450	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)3)4) 300.1210c) 300.1210d)2)3)4)A)B)C)D)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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	S9999	Attachment A Statement of Licensure Violations	

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resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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 care needs of the resident.

3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living

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S9999	Continued From page 2 shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 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: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. B) Each resident shall have at least one complete bath and hair wash weekly and as many additional baths and hair washes as necessary for satisfactory personal hygiene. C) Each resident shall have clean, suitable clothing in order to be comfortable, sanitary, free of odors, and decent in appearance. Unless otherwise indicated by his/her physician, this should be street clothes and shoes. D) Each resident shall have clean bed linens at least once weekly and more often if	S9999		

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S9999	Continued From page 3 necessary. 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. This REQUIREMENT is not met as evidenced by: A. Based on observation, interview and record review, the facility failed to provide treatment and services regarding a resident's excoriated sacral areas and follow their plan of care to protect and maintain skin integrity, promote wound healing, and prevent wound infection. This failure resulted in the development of a newly opened wound on R3's right upper thigh, and R2's excoriated sacral areas with active bleeding and was contaminated with urine-soaked incontinence brief. This applies to two of three residents (R2 and R3) reviewed for skin alteration. B. Based on observation, interview and record review the facility failed to monitor, identify, and provide specific care interventions for pressure ulcer prevention and treatment for two (R1 and R2) of three residents reviewed for pressure ulcers from a sample of 11. This failure resulted in R1's developing a new pressure ulcer categorized at an advance stage 3 pressure ulcer.	S9999		

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S9999	Continued From page 4 The findings include: 1. The EMR (Electronic Medical Record) shows that R3, a 70-year-old, with diagnoses that included metabolic encephalopathy, morbid obesity, diabetes mellitus type 2, neuropathy, congestive heart failure, vascular dementia, without behavioral disturbance, psychotic and mood disturbance, anxiety, Alzheimer's disease, hypertension, repeated falls, depression, COPD (chronic obstructive pulmonary disease), lack of coordination, reduce mobility, and Covid-19 positive. On 9/23/2023 at 11:30 A.M., R3, was in her room, was heard screaming for help. R3 can be heard from few doors away. R3 had been screaming for approximately 5 minutes. Surveyor proceeded to check R3. When seen, R3 was sitting in her wheelchair without a head rest. R3's neck and head were leaned back without support. R3's lower extremities and almost entire buttocks area were almost on the floor. R3's legs were spread open that seems to be stopping R3 from falling. R3's was not able to maneuver her hips/thighs and noted that her wheelchair size did not have enough space for R3 to maneuver. R3 was wearing tight legging pants. R3 was screaming "help, help, I want to go to bed! My hips and butt hurts, I cannot take it anymore, I have been sitting for long time and causing me pain." V18 (Director of Social Service/Manager on Duty on the initial day of survey/Saturday, 9/23/2023) was present during this observation. Surveyor asked V18 to get assistance. V7 (CNA/Certified Nurse Assistant) came and said she was the assigned CNA for R3. V7 said "I	S9999		

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cannot transfer nor reposition her in her wheelchair by myself. (R3) needed a minimum of 2 person assist for transfer and needed a mechanical transfer lift device for transfer to bed. I am waiting for another CNA to come and help me." Surveyor asked V18 to find another CNA to come and assist V7 to prevent R3 from falling. V10 (CNA) came to help. V10 said "there is no way we can reposition her (R3) from her wheelchair, the sling of the transfer device was placed incorrectly behind (R3's) back, we just have to use the lift device, support her legs and buttocks and slowly transfer her." V7 and V10 transferred R3 in bed. V7 and V10 unfastened R3's brief incontinence pad. R3 was observed with an open wound with an approximate size of a dime. The open wound was noted with dried maroon blood. The wound was also located along the linear mark on R3's right upper thigh close to the groin. The elastic band from the incontinence brief pad was indented to R3's skin and created a linear mark and an open wound to R3's right upper thigh. V7 and V10 said the wound and the linear mark was caused from the elastic band from the incontinence brief based on the placement of the tight elastic band that was indented to R3's skin. R3 was heavily soaked with urine and smear of stool when V7 had unfastened the incontinence brief. V7 said that she does not know how long R3 was sitting in her wheelchair. V7 said that R3 was already sitting in her wheelchair when she came in to work at 6:30 A.M., V7 said that she did not have time to provide ADL care assistance such as repositioning and incontinence care to R3 since she has a heavy load of residents and that R3 needed 2 persons assist for ADLs. V7 also said that R3's bed sheets were all soaked with urine and had formed a ring formation that was a stain from urine. V7 said "they just left her (R3) like

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that including the soiled bedding and smell of urine lingering around her room. I have to change the bedding but did not wash her (R3)." V7 also said that the open wound on the right upper thigh was newly developed. R3 said that due to her prolonged sitting without being repositioned, tight wheelchair, it had caused too much pain around her hips and buttocks area. It was also observed that R3's wheelchair had no seat cushion as a comfort device and R3 was seated directly on a vinyl material of the wheelchair.

The most recent MDS (Minimum Data Set) dated 9/12/2023 shows that R3 was cognitively moderately impaired with BIMS (Brief Interview Mental Status) score of 9/15, required extensive to total assistance from 2-3 staff assist for bed mobility, transfers, dressing, and toilet use. R3 required mechanical transfer lift device for transfers.

The care plan dated 9/12/2023 showed that R3 has an ADL self-care performance deficit related to weakness, decrease strength, low activity tolerance, due to diagnoses of metabolic encephalopathy, morbid obesity, limited mobility, impaired transfer ability. Interventions included for staff to provide extensive to total assist with transfer, bed mobility, locomotion, toileting, personal hygiene's, and bathing. To prevent skin alteration, the intervention was to keep skin clean and dry, check R3 every two hours and assist with toileting as needed, and provide loose fitting, easy to remove clothing. The care plan intervention also included for staff to ensure that R3 is centered in bed, positioning device is functional and up as appropriate, and trunk and extremities are properly aligned and supported. The care plan also showed for staff to check and

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S9999	Continued From page 7 ensure R3 is properly and safely positioned in bed or wheelchair. 2. R2, is a 67 -year-old resident with multiple diagnosis including cerebral palsy, paraplegia, osteomyelitis of vertebra, sacral and sacrococcygeal region, encephalopathy, anemia, lack of coordination, stage 4 pressure ulcer to the sacral region, and positive for Covid -19. R2 was originally admitted to the facility on 6/30/2023 and was readmitted on 7/7/2023. The Wound assessment dated 7/3/2023 showed that R2 was admitted to the facility with the following pressure ulcers: -7/3/2023 right buttock stage 3 pressure ulcer; measurement was 5.0 cm. x 5.0 cm. x 0.30 cm (Length x Width x Depth) -6/30/2023 sacrum stage 4 pressure ulcer; measurement was 6.50 cm. x 9.0 cm. x 0.80 cm. -7/24/2023 right scapula stage 2 pressure ulcer Admission Nursing Assessment dated 6/30/2023 showed that R2 was admitted with pressure ulcers. The most recent comprehensive MDS dated 7/24/2023 showed that R2 was alert and oriented, was cognitively intact with BIMS score of 14/15. The functional status showed that R2 required extensive to total assistance from 1-2 staff with regards to bed mobility, transfers, dressing, toilet use, hygiene, and bathing. R2 was also incontinent of bladder and bowel elimination. The POS (Physician Order Sheet) for the month of September shows an order dated 8/16/2023 for the sacral pressure ulcer wounds to "cleanse with normal saline or wound cleanser, pat to dry and apply skin prep to periwound, and apply (Brand name gel), cover with ABD (abdominal pads) and secure with tape Daily and PRN (as	S9999		

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S9999	Continued From page 8 needed) * may use foam/dry dressing." The care plan dated 9/21/2023 showed that R2 be turned and repositioned every 2 hours, kept clean and dry and apply moisture barrier for skin integrity management. On 9/23/2023 at 10:30 A.M. V8 (CNA) said that he does not know when R2 was last change with incontinence brief or last turned and repositioned as he had not taken care of him since he started his shift at 6:30 A.M. Together with V8, R2's skin and incontinence care was checked. R2 was lying in bed and said that " I was not change with my diaper since last night." V8 said that he tries to aid his assigned residents, but he was just overloaded with heavy care and not able to provide every 2 hours check and repositioning as required. V8 had unfastened R2's incontinence brief. The brief was heavily soaked with urine. The brief with padded absorbent foam material had already coagulated due to the heavily soaked urine. R2's entire skin of the sacral area was raw red, excoriated with blood dripping from the open excoriation of the sacrum/buttock areas. R2's pressure ulcer to the right buttock and sacrum pressure ulcer was exposed, and open wounds were in direct contact and contaminated with urine. There was no trace that a moisture barrier paste was applied to sacral excoriation and that the plan of care was followed to manage skin alteration. On 9/24/2023 at 12:51 P.M., V4 (Wound Treatment Nurse) said that R2 had pressure ulcers to the right buttock and sacrum V4 also said that R2's sacral region was excoriated and that a moisture paste skin barrier was the plan of care to preserved R2's skin alteration and prevent it from worsening. V4 said that "there should be a	S9999		

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S9999	Continued From page 9 trace of the moisture paste skin barrier even if (R2) was soaked with urine, which was the purpose of the skin barrier paste... it is very hard to remove the barrier paste, it has to be wipe multiple times to remove, you can visibly see if indeed the paste was applied." 3. R1 is a 47-year-old resident with multiple diagnosis including hemiplegia and hemiparesis due to cerebral infarction, affecting left dominant side, perforation of intestine, encounter for surgical aftercare following surgery on the digestive system; cutaneous abscess of abdominal wall, generalized muscle weakness, lack of coordination, Crohn's disease, Candida sepsis, depression, bipolar disorder, and positive for Covid-19. R1 was admitted to the facility on 6/14/2023. The Admission Nursing Assessment dated 6/14/2023 showed that R1 was admitted with no pressure ulcers. The most recent comprehensive MDS (Minimum Data Set) dated 6/25/2023 showed that R1 was alert and oriented, was cognitively intact with BIMS (Brief Interview Mental Status) score of 15/15. The functional status showed that R1 required extensive assistance from 1-2 staff with regards to bed mobility, transfers, dressing, toilet use, hygiene, and bathing. The MDS also showed that R1 had no negative behavior such as rejection of care. The assessment also showed that R1 was a high risk for pressure ulcer developing. The medical provider notes dated 9/22 and 9/18/2023 showed that R1 was calm, cooperative and was compliant with care. The care plan dated 9/22/2023 showed that R1 requires total assistance from staff for bed mobility, transfer, hygiene, and incontinence care.	S9999		

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S9999	Continued From page 10 The intervention was for R1 be assisted for ADL, be kept clean and dry and to check every 2 hours. The care plan showed no specific interventions to prevent R1 from developing pressure ulcer paying attention to heels and ankle areas since R1 had a foot drop to the left foot. On 9/23/2023 at 11:45 A.M., together with V6 (CNA/Certified Nurse Assistant) and V5 (Registered Nurse), R1 was checked in her room. Upon entering R1's room, R1 was observed lying in bed in supine position. R1 was alert and oriented. R1 was calm and compliant when asked for skin and incontinence check. V6 removed R1's blanket. R1's lower extremities were exposed. It was observed that R1's left leg was contracted and was on a fixed positioned and had leaned on an outward rotation. R1 also was noted with a left foot drop. The left foot was also had leaned towards an outward rotation making the ankle bone rubbed against the bed surface with no off-loading from pressure. There were 3 spots of brownish drainage on the bed sheet near R1's left foot. The brownish drainage was approximately the size of a golf ball. There was also a serous drainage noted coming out from the pressure ulcer of R1's left malleolus area (left ankle). The pressure ulcer was exposed and noted with approximate 0.5 cm. in depth. There was a whitish material seen inside the wound cavity. There was no dressing that cover the pressure ulcer. The exposed pressure ulcer wound with no cover was rubbing against bed surface and was not off loaded from pressure. R1 said that on 9/13/2023, she asked the therapist to have a look at her left foot since no staff had been checking her skin. R1 said she uses a boot during therapy. R1 also said she was worried since she does not feel any sensation to her lower extremities due to her medical	S9999		

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S9999	Continued From page 11 condition. R1 added that "once the therapist had checked my left foot, it was discovered that there was a big pressure ulcer on the left ankle. If they (staff) were checking my skin, then they would have seen it before it got to that size. No one checks it, and I am rarely repositioned, I just lay down here. I wait for the staff for at least 10 minutes to 3 hours to be turn and my diaper change. My diaper was not changed since early morning, nor I was repositioned." V5 (Registered Nurse) was present during this observation. V5 said that R1's pressure ulcer wound dressing should be always in placed to prevent infection. V5 also said that R1 had an order to replace the wound dressing if needed such as if it was soiled or was not intact. The POS (Physician Order Sheet) for the month of September 2023 showed a physician order dated 9/14/2023 for pressure ulcer wound dressing to the left ankle that included cleansing the wound with a normal saline solution, (Brand name) Gel, Calcium Alginate, top with a foam dressing. The wound dressing was to be done every three days and as needed. The POS also showed an order dated 9/14/2023 to off load heels for pressure relief. This order for offloading was after the fact that R1 had already acquired the pressure ulcer to the left ankle. The pressure ulcer of R1's left ankle assessment showed as follows: -9/13/2023 showed that R1 was identified with a stage 3 pressure ulcer to the left ankle. The measurement was 1.0 cm. x 1.50 cm x 0.10 cm (Length x width x depth). -9/21/2023: wound measurement was 2.00 cm. x 1.50 cm., 0.20 cm. -9/24/2023: wound measurement was 2.0 cm. x 1.50 cm. x 0.20 cm.	S9999		

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S9999	Continued From page 12 On 9/24/2023 at 12:51 P.M., V4 (Wound Treatment Nurse) said that R1 had acquired a stage 3 pressure ulcer to the left ankle on 9/13/2023. V4 added that the facility's policy and practice was to check each resident's skin during provision of care such as providing incontinence care, turning, and repositioning, shower, or bathing. V4 added that "if staff had been checking R1's skin, then the stage 3 would have been identified sooner and at a lower stage such as stage I, an intact skin with a persistent non-blanchable redness. A stage 3 was advance pressure ulcer, and it was a stage already a stage 3 when it was identified. It will not jump to stage 3 without starting from stage I, this should had been identified sooner if skin check was done during provision of care. This is our facility's practice and policy to check skin during provision of care such as hygiene, bathing, and incontinence care." V4 also added that R1 was a high risk for developing pressure ulcer. V4 added that intervention was to turn and reposition every 2 hours, keep clean and dry. V4 said that there "were no specific interventions related to prevention of pressure ulcer on the ankles especially the left ankle where the left leg was contracted and paralyzed." V4 added that she did investigated/assessed the left ankle on 9/13/2023 when the nurse that was assigned to R1 reported to her that the therapist had identified a pressure ulcer to the left ankle. V4 said it was a stage 3 pressure ulcer of the left malleolus (ankle) that it was undermined when it had started. On 9/24/2023 at 2:45 P.M., together with V2 (Director of Nursing), R1's EMR (Electronic Medical Record) was reviewed. V2 had stated that R1's Braden Scale dated 6/14/2023 was not accurate. V2 said that R1 was a high risk for	S9999		

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	IL6002174	A. BUILDING: _____ B. WING _____	C 09/29/2023

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developing pressure ulcer and if the Braden Scale was correctly done, then specific plan would have been triggered in R1's care plan. The care plan was also reviewed. V2 said there were no plan of care specific for pressure ulcer prevention and paying details to R1's lower extremities with left leg being paralyzed and a foot drop.

On 9/25/2023 at 3:01 P.M., V3 (Wound Care Physician) stated that he saw R1 for the initial evaluation on 9/20/2023. Together with V3, the wound documentation entered by him dated 9/20/2023 was reviewed with him during the interview. V3 said that he made a wrong entry of incorrect information that R1 had a pressure ulcer upon admission. V3 also verified that his documentation regarding unavoidable wounds were the surgical abdominal wounds due to perforation. V3 added that R1 was a high risk of developing pressure ulcer especially to the left lower extremity due to contracture, foot drop, and paralysis. V3 added that that "(R1's) stage 3 pressure ulcer to the left heel was preventable." V3 added that "if there were specific interventions that were put in place such as off-loading from pressure in bed or when up with a walking boot, this could have been prevented." V3 also added that nutritional interventions should have been included as preventative measure. V3 said that "I do not know why it was already a stage 3 when it was identified. If skin was monitored, there should have been signs of stage I, a lower stage and not a stage 3. There must be an existing sign such as redness, discoloration, painful to touch prior to becoming a stage 3 pressure ulcer. It was an overwhelming scenario when I went to see (R1) on 9/20/2023. The nurses and nursing assistants were overloaded with work, so I am not sure how residents' care such as offloading

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measure, repositioning timely were being done in a manner to prevent pressure ulcer. They were like working 50% work force as observed. I guess nobody wants to work because the facility was under special circumstances because of Covid outbreak." V3 said that he had debrided R1's pressure ulcer on 9/20/2023 and had removed 0.90 % of nonviable material of slough/fibrin quality/dead tissue. Surveyor asked V3 what the possible whitish material was seen as observed on 9/23/2023 if in fact it was debrided 90% of the non-viable tissues. V3 said "that was why I want the x-ray result if it was osteomyelitis related to bone infection so (R1) can be given correct treatment such as antibiotics as soon as possible. I will call them now (facility) to follow up with the x-ray result, this was ordered since 9/20/2023, I do not want any problem that might happened such as sepsis." V3 said "if only specific interventions including off-loading, skin monitoring, nutritional approach were in place, then this stage 3 pressure ulcer could have been prevented. I will revise my documentation to correct the wrong information."

The nutritional notes dated 9/19/2023 showed that it was only after the fact that R1 had developed stage 3 pressure ulcer when dietary intervention was addressed.

The policy for "Skin Prevention" dated 5/2017 showed "All residents will receive appropriate care to decrease the risk of skin breakdown. 2. All residents will be evaluated daily during care for any changes in their skin condition. 2. Dependent residents will be assessed during care for any changes in their in skin including redness (non-blanching erythema), and this will be reported to the nurse. The nurse will be responsible of alerting the Health Care Provider

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S9999	Continued From page 15 and the wound care coordinator. ...5. Residents unable to reposition themselves will be repositioned at least every two hours. Unless contraindicated, elevate heels off the bed surface and avoid skin -to-skin contact. 9. Clean skin at time of soiling and at routine intervals. 10. If incontinent, use a moisture barrier. " The policy for pressure ulcer wound dressing dated 6/9/2022 shows "Facility will ensure that the right environment will be provided all wounds to enhance and promote wound healing. 1. Wound or treatment nurse follows physician/NP (Nurse practitioner) order for the appropriate wound dressing." The policy for "Wound Prevention and Healing" dated 7/24/2023 showed "Braden Scale will be completed to determine the patient's level of risk and implement interventions to prevent development of pressure injuries. Facility will inspect skin during showers, daily and weekly skin checks as scheduled and as needed. Nurse will provide wound care per physician orders. The facility's policy for ADLs dated 10/20/2021 showed "Facility ensures that residents receive ADL assistance and maintains resident's comfort, safety, and dignity. 6. Assist the resident to be clean, neat and well-groomed." The facility's policy for urinary incontinence dated 6/16/2023 showed "Facility ensure and provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infection to the extent possible. Use check and change strategy that is done by checking resident's continence status at regular intervals..." The facility's policy for repositioning dated	S9999		

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S9999	Continued From page 16 7/20/2023 showed "Facility will provided guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed- or chair bound residents to prevent skin breakdown, promote circulation and provide pressure relief for resident...4. Residents who are in bed will be on at least every two-hour repositioning ...." (B)	S9999		