STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145045	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Naperville, The	200 Martin Avenue Naperville, IL 60540

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 - 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** 34117 Based on observation, interview, and record review, the facility failed to ensure a resident was free from sexual abuse. This resulted in R1 being being afraid and in shock. This applies to 1 of 3 residents (R1) reviewed for abuse in the sample of 3. The findings include: R1's face sheet shows she is a [AGE] year-old female admitted to the facility 8/9/23, with diagnoses including major depressive disorder, unspecified dementia, and frontotemporal neurocognitive disorder. R1's Minimum Data Set assessment dated [DATE] shows she is cognitively intact with a Brief Interview for Mental Status score of 15, with no behaviors of psychosis including hallucinations, delusions, no behavioral symptoms or rejections of cares. The facility's Initial Report, dated 10/21/24, documents R1 alleged housekeeping services V4 (Former Employee/Laundry Aide) exposed himself in an appropriate manner. The Final Report documents R1 alleged V4 entered her room and exposed himself while R1 was sleeping. An interview conducted with V4 stated, I have no answer, I do not know what happened. V4 has been employed at the facility as a laundry aide through a community program PAEP (Parents Alliance Employment Project), which is an organization that assists individuals with mild cognitive deficits to obtain and retain employment. R1's roommate was interviewed, but she was not able to recall any disturbances. V4 has been terminated from the facility. V4's statement, dated 10/21/24 at 3:45 PM, states, I do not know why this happened. I do not have an answer for you. I don't know what to say. (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 - Actual harm Residents Affected - Few	On 11/1/24 at 9:51 AM, R1 was observed in her room. She was well groomed, alert to person, time, and place. R1 said she has been at the facility over one year and a couple of months. On 10/21/24, in the afternoon, she was in her room lying down on her side facing the window. She was reading a book and fell asleep. She felt something near her face; she opened her eyes and V4 was standing there with his instrument out. She said she jumped from her bed. V4 left her room and stated, I didn't do anything. R1 ran out of her room and reported the incident to staff who were in the hallway. V4's genitals were fully exposed. R1 stated, I was afraid and in shock. R1 reported to V1 (Administrator) it was V4 who exposed himself to her. They called V4's brother and V1, Administrator, promised me he will never be back here. On 11/1/24 at 10:42 AM, V7 (Admissions Director) said on 10/21/24, she was walking down the hallway with V6 (Regional Director of Admissions), when R1 ran out of her room pointing to V4, and said he was in her room and exposed himself to her. R1 pointed to V4 and said, It was you. V4 said, I didn't do anything; I didn't do anything. R1 looked shocked and was visibly distraught. V7 stated she went to V1's office and reported the incident. On 11/1/24 at 11:13 AM, V6 (Regional Director of Admission) said she was walking down the hall on 10/21/24 with V7. R1 came out of her room and pointed to V4. R1 said V4 pulled out his penis and exposed himself to her. R1 was very upset and shaken up. On 11/1/24 at 10:53 AM, V8 (Maintenance Director) said V4 had been employed at the facility for about three months. He (V4) was hired as a laundry aide, but it did not work out. V8 said V4 had been helping him with maintenance. On 10/21/24, he was working outside with V4. He turned around and V4 was not there; he went inside the building and heard a resident yelling. He did not think of anything because that is common in this setting. He then heard his name paged over head to report to V1's office. (V1) asked me where (V4) was. I told (V1), (V4) was outside with me, but then I could not find (V4). V1 reported to him there was an incident with V4 and R1. V4 was in the laundry room. V8 said he asked V4 what happened. V4 was kind of confused and said, I didn't do anything. V8 said he escorted V4 to V1's office and he remained in the room. V1 asked him what happened, and V4 said he didn't remember. V8 said he reviewed the camera, and it showed V4 entering R1's room, but V4 said he does not remember going into R1's room. (V4) has some special needs, and usually does not go into resident rooms by himself, and I was supposed to be with him. (V4) left without telling me where he was going, and I did not know where he was. (V4) did not have any reason going into (R1's) room. (V4's) brother was notified and picked him up from the facility. On 11/1/24 at 11:26 AM, V3 (Assistant Director of Nursing/ADON) said she talked to R1 after the incident. (R1) told me V4 was a nice guy, but something was wrong with him. She said she was lying down sleeping and woke up with (V4's) genitals out in front of her. (R1) has been at the facility for a while, she is pleasant, she knows me by name and comes to me with concerns. R1 does not have any behaviors and if that's what she said happened, I have to believe her. On 11/1/24 at 11:31 AM, V10 (Social Service Director) said R1 reported to her she was lying down in her bed reading a book and V4 exposed himself to her. She followed him out of the room and reported the incident. R1 is alert and oriented and does not have a history of fabrication. V10 would call this abuse. On 11/1/24 at 11:39 AM, V9 (Certified Nursing Assistant-CNA) said R1 is alert with no behaviors. She lets staff know what she needs. R1 is very alert. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 11/1/24 at 1:12 PM, V1 (Administrator) said he was notified by V6 and V7 regarding the incident. (R1) said she was asleep in her room and (V4) exposed himself and she chased after him out of the room. V1 interviewed V4; he had a flat affect and stated, 'I don't know, I don't remember' repeatedly. This was a tough one, there was two different stories and there was no witness. I don't know what happened. If it did happen, V1 would consider this abuse. (V4) was terminated, out of the best interest of everyone, it was not the right setting for him. At 2:21 PM, V1 said he reviewed the camera, and it showed V4 entering R1's room at the same time of the alleged incident. It shows R1 leaving the room after V4 left her room and reporting the incident to V6 and V7, but V4 denied going into R1's room. The facility's Abuse Prevention Program and Policy states, residents have the right to be from abuse, neglect, exploitation, misappropriation, of property or mistreatment . Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means .