

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145473	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/18/2025
NAME OF PROVIDER OR SUPPLIER  Pearl of Orchard Valley		STREET ADDRESS, CITY, STATE, ZIP CODE  2330 West Galena Boulevard Aurora, IL 60506	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record reviews, the facility failed to ensure the safety and protection of R1, a female resident with severe cognitive impairment, from R2, a male resident with a documented history of wandering and entering other residents' rooms within the secured dementia care unit. This failure resulted in an incident on August 29, 2025, in which R2 entered R1's room without staff awareness. R2 had remained in the room with the door closed for approximately eight minutes. Staff later discovered R2 near R1, with his genitals exposed and near R1's face. This incident was a significant breakdown in supervision necessary to protect vulnerable residents from harm including sexual abuse. This applies to 1 of 2 residents (R1) reviewed for abuse, from a total sample of 11 residents. The facility's failure to supervise and protect R1 from sexual abuse constituted an Immediate Jeopardy to resident health and safety. The Immediate Jeopardy began on August 29, 2025, when staff member V4 (Restorative Aide) entered R1's room and observed R2 standing at the head of R1's bed. R2's sweatpants were lowered to his knee level, his genitals were exposed, and R1, who was asleep in a side-lying position, was facing R2. The facility administrator (V1) was notified of the Immediate Jeopardy on September 17, 2025 at 12:21 P.M. Through subsequent observations, staff interviews, and record reviews, the surveyor verified that the Immediate Jeopardy was removed on September 18, 2025. However, the facility remains in non-compliance at Severity Level 2 due to the need for additional time to evaluate the implementation and effectiveness of the corrective actions, including in-service training provided to staff. The findings include: The Electronic Medical Record (EMR) shows R1 is a [AGE] year-old female resident admitted to the facility on [DATE]. R1 has multiple diagnoses including dementia, cerebral atherosclerosis, unspecified psychosis, psychotic disorder, anxiety disorder and a recipient of hospice care. The most recent Minimum Data Set (MDS) dated [DATE] shows R1 has severe cognitive impairment, not able to recall her location, person, and place. R1 also showed no signs of psychosis including hallucination, delusion, and no negative behavior such as rejection of care and wandering. R1 is dependent on facility staff for ADLs (Activities of Daily Living). R1 also has limited range of motion to upper and lower extremities, with contractures to lower extremities. On September 9, 2025 at 12:15 P.M., R1 was observed in the secured dementia unit' dining room. V7 (CNA/Certified Nurse Assistant) was feeding R1 for lunch. R1 was confused and not able to carry a conversation, and not able to verbalize needs. V7 said that R1 was totally dependent from staff with all aspects of ADLs (Activities of Daily Living). V7 also said that R1 was not able to verbalize her needs and just utter incoherent words. The Electronic Medical Record (EMR) shows R2 is a [AGE] year-old male resident admitted to the facility on [DATE]. R2 has multiple diagnoses including unspecified dementia, bipolar disorder, alcoholic cirrhosis, alcohol abuse with intoxication, hepatic encephalopathy, malignant neoplasm of right kidney, and adjustment disorder. The most recent Minimum Data Set (MDS) dated [DATE] shows R2 is cognitively intact with BIMS (Brief Interview Mental Status) score of 14/15. R2's temporal orientation shows he can recall correct month and year, able to correctly repeat words with no cues required for the words repetition. The assessment also showed that R2 had no signs of delirium, inattention, disorganized thinking, and no altered level of consciousness. The mood assessment showed R2 was feeling down, depressed, trouble falling asleep, and feeling tired. R2 was assessed with no indicators of psychosis including hallucination, delusion, and misconception of belief. R2 was identified with behavioral symptoms such as exhibited physically pacing, rummaging, public sexual acts, disrobing in public and wandering that occurred 1-3 days in a period of 7 days. R2 has no impairment for upper and lower extremities, is ambulatory, and required only set up, and supervision for ADLs. On September 9, 2025 at 12:35 P.M., R2 was observed in the dining eating his lunch. R2 was aware of his location, his name and reason why he was at the facility. R2 said he was admitted to the facility after a hospitalization due to his kidney and liver condition. However, when surveyor asked regarding his wandering and what was he doing entering other residents' room he replied nothing. On September 9, 2025 at around 2:30 P.M., R2 was again observed. R2 was ambulatory, was found by the entrance of the 700 unit. V10 (CNA/Certified Nurse Assistant) who was supposed to be providing direct supervision to R2, was at the nurse's station, and had her back from R2, with no visual control and V10 was providing hair care to another resident. The facility's incident report dated September 4, 2025 showed an event investigation of sexual abuse dated August 29, 2025 at 11:30 A.M. The incident report showed that staff had expressed concern of R2 standing at the head of R1's bed with R2's pants lowered. During the discovery of this situation R1 was</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to timely report allegations of sexual and verbal abuse to the residents' Power of Attorney (POA), physician, the Illinois Department of Public Health (IDPH), and the local police department in accordance with the facility's abuse policy. This applies to 2 of 4 residents (R1, R3) reviewed for abuse in the sample of 11. The findings include: 1. The EMR (Electronic Medical Record) shows that R1 is a [AGE] year-old female, admitted [DATE], with diagnoses including dementia, cerebral atherosclerosis, unspecified psychosis, anxiety disorder, and is under hospice care. The Minimum Data Set (MDS) dated [DATE], indicates R1 has severe cognitive impairment and requires total assistance for Activities of Daily Living (ADLs). The EMR shows that R2 is a [AGE] year-old male admitted [DATE], with diagnoses including dementia, bipolar disorder, alcoholic cirrhosis, and adjustment disorder. The MDS dated [DATE], indicates cognitive intactness (BIMS 14/15), and a history of inappropriate behaviors such as wandering and entering other residents' room. The incident detail showed that on August 29, 2025, at 11:30 AM, an incident involving R2 exposing his genitals to R1 in R1's room was observed. R2 was alone in R1's room for approximately 8 minutes with the door closed, as confirmed by video surveillance footage. R2 was seen exiting R1's room with sweatpants still not fully pulled up. On September 9, 2025 at 12:12 P.M., V4 (Restorative Aide) said she entered R1's room at approximately 10:54 AM on August 29, 2025 and observed R2 standing by R1's head, with pants lowered to the knees and buttocks exposed, while R1 was lying sideways, facing R2. The incident report showed the sexual abuse allegation was identified on August 29, 2025, R1's POA was notified 7 days later, on September 4, 2025.; IDPH was notified on September 4, 2025, a 6 -day delay; local police were not notified until 10 days after the incident. On September 10, 2025 at 1:10 P.M., V16 (R1's Family/POA) expressed dissatisfaction regarding the delay, stating that potential evidence was lost. On September 10, 2025 at 2:31 P.M., V18 (Hospice Physician) had confirmed that neither him nor his alternate physician were notified. V18 added that if they would have been notified timely, an appropriate evaluations or treatments could have been initiated. On September 22, 2025 at 2:59 P.M., V22 (Primary Physician) had validated that neither him or his alternate was not informed and stated appropriate evaluations or treatments could have been initiated had they been notified timely. On September 9, 2025 at 3:30 P.M., V1 (Administrator) explained that the delay of reporting was he was new. 2. The EMR shows that R3, is an [AGE] year-old, and was admitted to the facility on [DATE]. R3's diagnoses included unspecified dementia, major depressive disorder, PVD (peripheral vascular disease) and localized swelling. The MDS dated [DATE] showed that R3's cognition was moderately impaired and that she required substantial assistance from staff for ADLs (Activities of Daily Living). The EMR shows that R4, a [AGE] year-old admitted to the facility on [DATE]. R4's diagnoses included unspecified dementia, anxiety disorder and diabetes mellitus. The MDS dated [DATE] showed that R4 is moderately impaired in cognition and required supervision with ADLs. The facility's abuse allegation report showed that there was a verbal altercation between R3 and R4 on August 29, 2025. The abuse allegation report showed that R3 had sustained a skin tear and was bleeding from her lower leg. The bleeding was a skin tear was sustained and hit her leg, when R3 was startled from R4's shouting to R3. This abuse investigation was reported to IDPH on September 4, 2025, which was 6 days after the verbal abuse allegation was identified. V1 had the same response as to the reason of delayed reporting. The facility's Abuse Prevention Policy (dated October 24, 2022) states: The Administrator or designee shall notify the resident's representative, the physician, and shall notify the local police department of any suspicion of criminal activity immediately.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to conduct a comprehensive investigation into an allegation of sexual abuse. As a result, the facility prematurely concluded the allegation to be unsubstantiated without completing all required investigative steps. This applies to 1 of 2 residents (R1 and R2) reviewed for sexual abuse allegations in a sample of 11 residents. The findings include: The facility's incident report dated September 4, 2025 showed an event investigation of sexual abuse dated August 29, 2025 at 11:30 A.M. The incident report showed that staff had expressed concern of R2 standing at the head of R1's bed with R2's pants lowered. During the discovery of this situation, R1 was asleep. V4 (Restorative Aide) was the one who discovered this incident. The report showed that V4 asked R2 what he was doing, and that R2 immediately pulled his pants up, turned around and replied nothing. On September 9, 2025 at 12:12 P.M., V4 was asked about the incident. V4 also demonstrated in R1's room how she saw R2 in R1's room. V4 started by saying that she went to the designated dementia unit around 11:00 A.M. to take R1's weight. V4 said that she went directly to R1's room, in which the door was closed. V4 said that she opens the door and saw R2 standing next to R1's head of bed. V4 said that from the entrance door, R1's bed was approximately 10 feet away. V4 said that R2's sweatpants were lowered to the knee level, and R2's buttocks were exposed. V4 said that during that time, R1's bed was positioned low, close to floor level, so it was approximately the height of bed was to R2's knee level. V4 added that R1 was lying sideways facing the door and this meant was facing R2. V4 said that she only saw R2 from behind, however, R2 pants was lowered all the way to his knees and she saw his bare buttocks. V4 added that R2's position was standing to the level of R1's head level. V4 further said that since R2 was standing to R1's head level and that R1 was facing R2, it was just few inches that R2's genitals were closed to R1's face. The facility's video surveillance footage was reviewed on September 10, 2025 at 9:29 A.M. for the date August 29, 2025 regarding R1 and R2's incident. V1 (Administrator) and V14 (Human Resources) were present during the review of surveillance footage. The surveillance footage showed the following: -at 10:46:00 A.M., R2, came from the designated dining room in the dementia unit, was ambulatory, no assistive devices. -at 10:46:39 A.M., R2 directly headed to R1's room, passing 3 residents' rooms. R2, open R1's closed door, entered R1's room, then closed the door. -at 10:54: 03 A.M., V4 entered the designated dementia unit, went directly to R1's room. -at 10:54:20 A.M., R2 was walking out from R1's room, with his sweatpants not totally pulled up since R2's lower abdominal area was still exposed. R2 went directly to his room. The video surveillance footage confirmed that R2 was alone in R1's room for 8 minutes, with door closed. There was also no staff present in the hallway during this period. R2 exited R1's room with his pants still not fully pulled up. Multiple separate interviews held with direct staff V7 and V8, V10, V13, (CNAs), V9 (Nurse), and V15 (Social Service Director) on September 9 and 10, 2025. They said that R2 was known to be a wanderer, going into each residents' rooms, rummaging into residents' closets, and sometimes take other residents belongings. V7, V8, have said (R2) is sneaky, when he knows no staff was around him, or was not looking, (R1) goes to residents' rooms. They have expressed concerns that this incident may not have been the first of its kind, only the first caught. They all said that R2 can be confused or forgets but knows what he was doing. They also said that (R2) makes sound conversations, knows his family members, was sneaky, look at staff, and when staff was not looking, (R2) goes to other residents' rooms, taking their stuff. We take care of approximately 13 residents per CNA, cannot watch everything, by the time something happened, it was already too late. V15 said that R2 was cognitively intact, reminded of boundaries and understood the reminders but remained wandering around other residents' rooms. V15 confirmed that the secured unit housed 19 residents, 8 female and 11 males, with moderate to severe cognitive impairment. V15 said there was no individualized plan addressing R2's inappropriate wandering behaviors, going to other residents' rooms, going through their closets, and taking their belongings aside from the standard 2-hour monitoring. On September 9, 2025 at 1:30 P.M., V6 (Licensed Practical Nurse) said that she was with V7 when she checked R1 after the incident. V6 said she had check R1's skin and nothing significant was noted. V6 then informed V5 (Registered Nurse) and V5 did the documentation as V5 was in the nurse's station in charge of the computer entry. On September 9, 2025, V5 said that she documented into R1's progress notes that R1's skin checked done. Review of the progress notes dated August 29, 2025 documented by V5 showed no other documentation to indicate possibility of physical contact when R2 was found with exposed genitals. This includes R1's condition of her face, any redness, irritation, condition of hair</p>		