STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145473	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Orchard Valley	2330 West Galena Boulevard Aurora, IL 60506

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their policy for notification of resident's change in condition. This applies to 1of 3 residents (R1) reviewed for falls in the sample of 6.The findings include:R1's EMR (Electronic Medical Record) showed R1 was admitted to facility on May 21, 2025, with the diagnoses of chronic obstructive pulmonary disease, hypertension, anxiety, metabolic encephalopathy, wedge compression fracture of fifth lumbar vertebra, disorders of bone density and structure, falling, fracture of lower end of left femur, atrial fibrillation, hypothyroidism, lack of coordination, urinary tract infection, and cirrhosis of liver.R1's MDS (Minimum Data Set) dated February 17, 2026, showed R1 was cognitively intact. The MDS continued to show R1 required maximal assistance from facility staff with toileting hygiene and moderate assistance from facility staff for transfer. On March 9, 2026, at 11:50 AM, R1 stated she had a fall during the night on February 24, 2026, when she put on her call light because her incontinence brief was wet. R1 stated the CNA (Certified Nursing Assistant) answered her call light, R1 told her she needed to be changed, and the CNA said she would be back. R1 stated she couldn't wait any longer and needed to urinate so R1 attempted to get to her wheelchair to take herself to the bathroom and fell forward. R1 stated she used her cell phone to call the facility to notify the nurses she had fallen and needed assistance. R1 stated she sustained a skin tear on her left arm and told the nurse she was having back pain. R1 said she had pain throughout the night. R1 stated in the morning, V19 (pulmonary nurse) came to her room and asked R1 what happened. R1 stated she told V19 she had fallen the previous night. R1 stated V19 called the ambulance, and she was transported to the local hospital. R1 stated while in the hospital she had a surgical procedure for her back pain.On March 10, 2026, at 12:34 PM, V19 (Pulmonary Nurse) stated she assessed R1 on the morning of February 24, 2026, around 8:30 AM, and R1 did not seem like herself. V19 stated R1 is normally cognitively intact. V19 stated R1 had a protruding quarter sized hematoma on the right side of her forehead and a skin tear to her left arm. V19 stated R1 told V19 she had fallen last night. V19 stated she asked R1 if she was in pain and R1 replied, yes on her back. V19 said R1 was on anticoagulant medication and was sent out via emergency services.A progress note dated February 24, 2026, at 8:59 AM, by V19 showed This nurse was at bedside at 8:40 AM to give first pulmonary treatment of the day. At this time, resident was confused. Mentation status, alert and oriented times one. Per resident, she stated she fell sitting on the side of her bed trying to help her mom. Vitals performed, within normal limits. Blood pressure 117/73, heart rate 78. Respiratory rate 20. No fever noted. Hematoma noted to right forehead and skin tear to left upper extremity. Notified Administrator and DON (Director of Nursing). Resident on [apixaban]. Sent out immediately via [Emergency Medical Services). DON notified nurse practitioner.On March 10, 2026, at 3:50 PM, V2 (DON) stated the facility's policy is to attempt to call the primary doctor twice and if they cannot be reached then the nurse should call the medical director, and document each attempt. V2 stated V16 (Nurse) said she called and left a message with R1's doctor. V2 stated there was no further documentation to show that V16 spoke with a doctor or made more attempts at contacting R1's doctor regarding R1's unwitnessed fall. V2 stated V16 should have followed the facility's policy. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility does not have documentation to show V16 notified R1's physician or the medical director after R1's unwitnessed fall. The facility does not have documentation to show R1's representative was immediately notified of R1's fall.R1's Fall Event assessment dated [DATE], at 12:30 AM, by V16 showed V21 was notified on February 24, 2026, at 12:00 AM (prior to the time of the fall), and V20 (R1's Daughter) was notified at 5:00 AM.The facility's policy titled, Policy: Notification of Change in Condition, Discharge and Transfer with revision date on 1/15/2026, Policy Statement: It is the policy of this facility that changes in a resident's condition treatment are immediately shared with the resident and/ or resident representative, according to their authority, and reported to the attending physician or delegate (hereafter designated as the physician). Procedure 1. The nurse will immediately notify the resident, resident's physician and the resident representative(s) for the following (list is not all inclusive) a. An accident involving the resident, which results in injury and has the potential for requiring physician intervention.3. Document the notification and record any new orders in the resident's medical record.Provider Escalation Pathway for Emergent situations 1. Primary Attending Physician or Nurse practitioner/ Physician Assistant call immediately and document time, number and response. 2. If no response within 15-30 minutes (or sooner if urgent): Call again and leave a message or send secure text/fax if available. 3. If still, no response: Contact the Medical Director or the on-call covering provider. 4. If Medical Director is unavailable: Contact the on-call physician group, covering provider or telehealth provider per facility protocol. 5. If the resident is unstable or requires immediate treatment: Call [Emergency Medical Services] and send the resident to the hospital. Provider notification does not delay emergency care.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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** Based on interview and record review, the facility failed to keep residents free from sexual abuse when R3 sucked on R2's breast. This failure resulted in Immediate Jeopardy. The Immediate Jeopardy began on February 9, 2026, at 11:30 AM, when R2, a female dementia resident with known inappropriate sexual behaviors was left unsupervised in the dining room with R3, a male dementia resident, and R2 waved R3 over, lifted her shirt, and R3 sucked on R2's breast. This applies to 2 of 4 residents (R2 and R3) reviewed for sexual abuse in the sample of 6. V3 (Assistant Administrator), V17 (Senior Administrator), and V18 (Regional Nurse Consultant) were notified of the Immediate Jeopardy on March 10, 2026, at 11:47 AM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on March 10, 2026, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. The findings include:The facility's State Report dated February 13, 2026, by V15 (Previous Administrator) showed Incident Date: February 9, 2026. Time: 11:30 AM. [R3] is an [AGE] year-old male long-term care resident. [R3] has diagnosis of psychotic disturbance, diabetes mellitus, arteriosclerotic heart disease, dementia, major depressive disorder, anxiety, and myelopathy. R2 is an [AGE] year-old female long-term care resident. R2 has diagnosis of dementia, chronic obstructive pulmonary disease, diabetes mellitus, altered mental status, and bipolar disorder. At approximately 11:30 AM, it was reported to the abuse coordinator that R2 was noted to have her shirt raised, and [R3] was noted to have his face on her chest. Staff immediately separated [R3] from R2 and took [R3] to his room and kept him on one on one with a staff person until EMS (Emergency Medical Services) transferred to the ER (Emergency Room). Nurse assessed R2 for any signs of injury and none were noted. The police were notified and they interviewed [R3]. R2 told the officer that nothing happened that she didn't want to happen. R2 was sent to the ER for evaluation and returned with no new orders. [R3] was placed on the men's secure unit upon return from the hospital and R2 was moved to the women's secure unit. IDT (Interdisciplinary Team) conducted a thorough investigation that included staff and residents. Staff state that [R3] and R2 were last seen sitting at separate tables after eating lunch in the dining room. An interview with residents on the same unit revealed that no one has been touched inappropriately, and all feel safe at the facility. The interview of R2, who scores a 15 on her BIMS (Brief Interview for Mental Status) reveals that she called [R3] over and lifted her shirt for him, but the next day didn't recall anything happening. The interaction occurred briefly in a supervised area and was immediately addressed by staff that were present and supervising the dining room. No abuse was substantiated, and safeguards were implemented to protect both residents. Care plan will be updated with appropriate interventions for both [R3] and R2. Residents are doing well on their new units. Family was notified and satisfied with the outcome of the investigation. R2's EMR (Electronic Medical Record) showed R2 was admitted to the facility on [DATE], with multiple diagnoses including atherosclerotic heart disease, dementia, anxiety, and bipolar disorder. R2's MDS (Minimum Data Set) dated December 1, 2025, showed R2 was cognitively intact. The MDS continued to show R2 has one to three days of physical behavior symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually). R2's behavior care plan dated July 13, 2015, showed I, [R2], have a history of socially inappropriate behavior and display a lack of boundaries. I am noted to objectify males through sexually oriented behavior/comments. When my behavior is addressed, I minimize how my actions may be interpreted or impact others. As evidenced by: I have made crude, sexually oriented, profane and suggestive remarks (i.e. statements to male staff members about 'taking care of her' and 'get on top of me'). I over-step personal boundaries by getting too close to others, initiating sexually related behavior, making sexually oriented gestures and behaving in an uninvited and flirtatious manner. The care plan (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	continued to show multiple interventions dated July 13, 2015, including Unsupervised visiting with male residents should be discouraged and prevented when possible. R3's EMR showed R3 was admitted to the facility on [DATE], with multiple diagnoses including dementia, major depressive disorder, and anxiety disorder. R3's MDS dated [DATE], showed R3 had moderate cognitive impairment. The MDS continued to show R3 exhibited wandering behavior for one to three days of the assessment period. R3's behavior care plan dated July 15, 2024, showed Resident displays socially inappropriate behavior related to: diagnosis of unspecified dementia, major depressive disorder, anxiety disorder. As evidenced by: voicing inappropriate behavior toward a peer including getting close and behaving in a flirtatious manner. The care plan continued to show multiple interventions dated February 9, 2026, including, Administer medication and monitor for effectiveness. As indicated, discuss [R3]'s situation with the physician, licensed clinical social worker, family or psychiatrist. Discourage inappropriate remarks, behaviors toward female staff and peers. Notify family of any instances of behaviors. Communicate assertively that resident exercise control over impulses and behavior. On March 9, 2026, at 12:18 PM, R2 said R3 sucked on her breasts. R2 said it was a freak accident. R2 said she wanted R3 to suck on her breast. R2 said she didn't know today's date, but it was September of 2026. On March 9, 2026, at 12:22 PM, R3 said he does not remember the incident. R3 said R2 and him were friends and spent a lot of time together. On March 9, 2026, at 12:39 PM, V5 (Dietary Aide) said she was setting up for lunch on February 9, 2026, when she walked into the dining room and saw R3 sucking on R2's breast. V5 said she told the residents to stop and went to get nursing staff at the nursing station. V5 said she immediately told the administrator. V5 said no other staff members were present in the dining when R2 and R3 were making inappropriate contact. V5 said she watched the security footage of the dining room with administration and the video showed R2 and R3 were making inappropriate contact whenever staff would leave the dining room and then stop when someone would enter. V5 said she guesses she walked in too fast for the residents to notice and she caught them. V5 showed the surveyor the residents were seated at a table at the center of the dining room. On March 9, 2026, at 1:53 PM, V8 (CNA/Certified Nursing Assistant) said she had put drinks in the dining room and saw R2 and R3 sitting together at a dining room table. V8 said the food hadn't arrived yet so V8 left the dining room, and no other staff were in the dining room. V8 said V5 alerted staff and V8 ran into the dining room and separated R2 and R3. V8 said R2 has been verbally inappropriate with other residents by talking to them about her private areas. V8 said R2 would ask the residents to do something sexual to her private areas. V8 said if she heard an inappropriate comment, she would separate R2 and report it. V8 said the nurse would talk with R2 and tell R2 it was inappropriate. On March 9, 2026, at 1:43 PM, V6 (CNA) said R2 can be sexual at times, it depends on R2's mood. V6 said she was unaware R2 had any special interventions in place for her sexual behavior. V6 said staff only do continuous monitoring of the dining room once meals have been served and residents are eating. On March 9, 2026, at 1:48 PM, V7 (CNA) said she is caring for R2 today, and there is no additional monitoring required for R2. On March 9, 2026, at 3:46 PM, V14 (RN/Registered Nurse) said R2 has sexual behaviors and says sexually inappropriate comments to males. V14 said R2 is not able to give informed consent. V14 said if consent is required for R2, R2's family is called. V14 said R2 thought some male residents liked her, and when R2 would see these residents, she would make inappropriate sexual comments. V14 said staff would try to separate her and put her with female residents. V14 said R2 used to reside in the co-ed dementia unit. V14 said the intervention in place for R2's inappropriate sexual behavior was when R2 would say something inappropriate, staff would separate R2 from the other resident. On March 9, 2026, at 3:01 PM, V10 (Social Services Director) said R2 can be flirtatious. V10 said when she interviewed R2 after the incident, R2 told V10, R2 waved R3 over and lifted her shirt and R3 was kissing R2's chest. V10 said when she interviewed R3, R3 said he could recall the incident and R2 waved R3 over, R3 went up to R2, R2 lifted her shirt, and R3 kissed R2's chest. V10 said she calls sexually inappropriate behavior flirtatious behavior. V10 said R2 has said to V10, Ooooh baby, come over here. V10 said R3 is also flirtatious with her. V10 said (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	she contacted V11 (Psychiatric Nurse Practitioner) and V12 (LCSW/Licensed Clinical Social Worker) regarding the incident with R2 and R3. On March 9, at 4:05 PM, V12 (LCSW) said he met with R3 on February 12, 2026, following the incident but was unable to meet with R2 on February 12 because she refused to speak with V12. V12 said he has not attempted to see R2 again after she refused. V12 said he comes to the facility to see residents five days a week, Monday through Friday. V12 said he should have attempted to see R2 again since that day. V12 said R3 is not cognitively intact and cannot make his own decisions. V12 said R2 is not able to make informed decisions. V12 said he was aware R2 had inappropriate sexual behaviors and V12 thinks staff were just used to it by now because R2 was flirtatious with staff and residents. V12 said all they could do was document R2's behaviors and attempt to redirect R2. On March 9, 2026, at 6:13 PM, V11 (Psychiatric Nurse Practitioner) said R2 has a diagnosis of dementia does not have the decision-making capacity to consent to sexual activity/contact. V11 said he was not given all the details regarding R2 and R3. V11 said he was told there was an allegation but V11 was unaware contact was made between the residents. V11 said R2 could not be deemed decisional without further testing by a neuropsychologist due to R2's dementia diagnosis. R2's Psychiatric progress note dated January 20, 2026, at 9:59 AM, by V11 showed Visited January 19, 2026. MSE (Mental Status Examination): This patient was personally examined by the writer. Speech: The patient's speech exhibited an impaired rate, rhythm, low volume, and altered prosody, with noticeable latency in responses. Mood: The examination revealed a labile mood with a congruent affect. Thought Processes and Associations: the patient's thought processes displayed abnormal associations and impairments in processing and abstraction. Thought Content: The patient did not report any suicidal ideation, homicidal ideation, violent thoughts, auditory or visual hallucinations, or delusions. Insight/Judgement: The patient's insight and judgment are considered poor. Cognitive: the patient is alert and oriented to person only, with significant deficits in both short and long-term memory, as well as impaired attention and concentration; however, language skills and general knowledge are appropriate for their cognitive status. R3's psychiatric progress note dated December 26, 2025, at 12:02 PM, by V11 showed Visited on: December 22, 2025. MSE: The patient was personally examined by the writer.Thought Processes and Associations: The patient's thought processes displayed abnormal associations and impairments in processing and abstraction. Thought Content: The patient did not report any suicidal ideation, homicidal ideation, violent thoughts, auditory or visual hallucinations, or delusions. Insight/Judgment: The patient's insight and judgment are considered poor. Cognitive: The patient is alert and oriented to person only, with significant deficits in both short and long-term memory, as well as impaired attention and concentration; however, language skills and general knowledge are appropriate for their cognitive status. R2's EMR showed a progress note dated February 10, 2026, at 4:07 PM, by V23 (R2's Doctor), including Patient being seen for general follow up. Patient was seen while in her room. Patient had an incident yesterday, when she provoked another resident to suckle on her bosom. [Emergency Medical Services] was called, and police came to investigate. Patient does not seem to recall the events when asked about it. On March 10, 2026, at 11:47 AM, V18 said she thought sexual abuse was unsubstantiated because both residents enjoyed the act. On March 12, 2026, at 12:32 PM, V7 said she was caring for R2 in the female secured dementia unit. V7 said when she entered R2's room this morning, R2 said to V7 I want to f*** you. V7 said she left R2's room and when she returned, R2 said the same thing about another male resident outside of the dementia unit. V7 said she redirected R2 and said she can't speak like that and reported the behavior to the nurse. The facility's policy title Abuse Policy and Procedure dated October 24, 2022, showed Policy Statement: Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This includes but is not limited to corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Purpose: The purpose of this policy and the Abuse Prevention Program is to describe the process for identification, assessment, and protection of residents from abuse, neglect, misappropriation of property, and exploitation. The facility prohibits abuse, neglect, (continued on next page)

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Within five days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken to respond to the to the allegation, will be sent to the Department of Public Health. i. Report contents. The final report shall include the following, as appropriate: name, age, diagnosis and metal status of the resident allegedly abused, neglected, exploited, mistreated, or from whom property was misappropriated; the original allegation (note day, time, location, the specific allegation, he alleged perpetrator, witnesses to the occurrence, circumstances surrounding the occurrence and any noted injuries); a summary of facts determined during the process of the investigation, review of medical record and interview of witnesses; and conclusion of the investigation based on known facts. iii. Corrective Actions. The administrator shall take appropriate corrective action and disciplinary action, if deemed appropriate and necessary. F. Quality Management Review. Any investigation that concluded that abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred shall be reviewed by the facility Quality Management committee for possible changes in facility practices to ensure that similar events do not occur again. The investigation shall be reviewed at the next quarterly Quality Management committee meeting, or sooner if possible. The facility's policy titled Policy and Procedure: Sexual Abuse Prevention, Reporting, and Response dated February 18, 2025, showed Policy Statement: It is the policy of this facility to maintain a zero-tolerance stance toward sexual abuse, sexual assault, sexual harassment, or any form of non-consensual sexual contact involving residents. All staff, contractors, volunteers, and visitors must comply with federal and state regulations to protect residents' rights to dignity, privacy, and safety. The facility will ensure immediate protection of residents, prompt reporting to proper authorities, thorough investigation, and corrective actions in compliance with IDPH (Illinois Department of Public Health) and CMS (Centers for Medicare and Medicaid Services) requirements. Definitions: Sexual abuse: Non-consensual sexual contact of any type with a resident. Includes sexual assault, harassment, coerced nudity, inappropriate touching, photographing, or exposing residents without consent. Perpetrator: May include staff, other residents, volunteers, visitors, or contractors. Consent: The resident's ability and right to make an informed, voluntary decision. Consent cannot be given if the resident is cognitively impaired or under duress. The facility's policy titled Policy: Management of Sexual Behaviors dated September 18, 2025, showed Policy Statement: This long-term care facility affirms and respects the rights of consenting adults to privately engage in a private intimate relationship and pursue a meaningful quality of life. The facility emphasizes care in a manner and environment that enhances dignity and respect with full recognition of each person's individuality. The health care team recognizes the need to intervene when questions regarding informed consent and/or decisional capacity arise. It is the objective of this policy to clarify the issue of informed consent and the facility's potential role in educating individuals about appropriate sexual expression and safe practices. In-service education will address the content of his policy, as appropriate. Addressing questions of informed consent: 1. Definition: Informed Consent is defined as having the capacity to understand the outcome and consequences of one's actions. A person who does not understand, nor cannot explain the consequences of his/her decisions will be considered clinically incompetent. A specific diagnosis does not automatically imply a person can or cannot give informed consent. A person with dementia or severe mental illness may meet the legal and clinical standard defined above and therefore be capable of giving informed consent. As (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	appropriate the organization may utilize a mental health practitioner, such as a psychiatrist, clinical social worker and/or clinical psychologist to help in the evaluation and determination of the individual's ability to provide informed consent. 2. The facility will not intervene in situations in which two consenting adults are privately engaging in intimate behavior. The facility will be responsible for intervening in situations in which one or both individuals lack the ability to provide informed consent. Interventions may include, but are not limited to, verbal guidance, re-direction, firm limit setting, separation, escorting one or both individuals to a more closely supervised area, notification of appropriate responsible parties, notification of the attending physician and psychiatrist, counseling, reality orientation and appropriate distraction. 3. The facility respects privacy and encourages residents to appropriately pull privacy curtains and close doors when engaging in behavior of a sexual nature. Evaluation and education of residents: 1. In situations in which it is difficult to assess a resident's ability to give informed consent the facility may request further assessment from professionals such as the attending physician, attending psychiatrist and licensed clinical social worker. Special interventions may be implemented based on recommendations from the above professionals. The Immediate Jeopardy that began on February 9, 2026, was removed on March 10, 2026, when the facility took the following actions to remove the immediacy: 1. Corrective Actions Takena. R2 continues to reside in the facility with no further incidents and suffered no negatives effects.b. R2's physician and responsible party were notified on February 9, 2026; responsible party had no concerns.c. R2 was sent to the hospital on February 9, 2026; no new findings and no new orders were received.d. R2 was moved to the secured female unit on February 11, 2026e. R3 continues to reside in the facility with no further incidents and suffered no negative effects.f. R3's physician and daughter were notified on February 9, 2026; daughter voiced no concerns.g. R3 was sent to the hospital on February 9, 2026; no new findings and no new orders were received. R3 was on a 1:1 with staff until R3 left for the hospitalh. R3 was moved to the secured male unit on February 9, 2026.i. Law Enforcement was notified on February 9, 2026, and concluded investigation with no findings. Report #AUP260-16372.j. Social Services completed assessments on behavior, potential abuse and trauma on February 9, 2026, for R2 and R3. Care plans were reviewed and updated as indicated on potential for abuse, behavior and trauma. Assessments and care plans will completed per assessment schedule and as needed. Goal: completedk. On March 10, 2026, Social Services completed and reviewed assessments on residents identified with sexually inappropriate behaviors. Care plans were reviewed and updated as needed. DON (Director of Nursing), ADON (Assistant Director of Nursing) and/or designee communicated plan of care to staff. On March 10, 2026, a behavior monitoring binder was created and placed at the nurses' station that shows residents with behaviors and their plan of care and will be reviewed and updated by DON, ADON, Social Services, and/or designee weekly and as needed. Goal: ongoingl. For identified residents with sexually inappropriate behaviors, behavior monitoring started every 2 hours times 2 weeks and every shift thereafter while awake by nursing staff and will be documented on behavior monitoring log. Findings will be escalated to abuse officer and ADON for protocol implementation immediately. Start: March 10, 2026; goal: March 24, 2026/ongoing.2. Identification of Other Residents at [NAME]. All residents in the facility are considered potentially affected.3. Systemic Measures to Prevent Recurrencea. Resident Interviews of approximately 105 residents was conducted by Social Service and/or designee on March 10, 2026; Residents feel safe and with no concern on any potential and actual abuse.b. Daily Huddles with nursing staff and facility IDT (Social Service, Admin, MDS, Therapy, Activity): DON/ADON/Charge Nurse initiated review on new behaviors, interventions, and reports of suspected abuse daily. Behavior monitoring binder at the nurses' station with residents with sexually inappropriate behaviors with appropriate and updated plan of care. Start date: March 10, 2026; goal: ongoing.c. Staff Education: Facility-wide training on sexual abuse policy and behavior management for sexually inappropriate behaviors including following care plan interventions. Training was conducted by DON, ADON, MDS Director. Agency staff were included with training. This training began (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Orchard Valley	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	on March 10, 2026, and will be ongoing. Facility staff who didn't receive training will not be allowed to start their shift unless training has been completed including agency staff. DON, ADON, MDS Director, and/or Charge nurse were assigned to complete training for new agency staff and for facility staff (all departments) who haven't received the training after work hours. Re-education will be conducted quarterly and as issue on any type of abuse would arise. Goal: ongoing.d. On March 10, 2026, Administrator and Consultants reviewed abuse policy that includes sexual abuse:i. Residents will be assessed upon admission for potential for abuse/trauma and behaviors such as sexual inappropriateness. This will be followed by an assessment quarterly, annually and as neededii. Residents will be screened and assessed by Social Services to identify any inappropriate behaviors. Care plans, interventions, and targeted inappropriate behavior monitoring orders will be added by a nurse as indicated.iii. Any new behaviors will be discussed by the IDT with Administrator, DON, Assistant Director of Nursing and/or consultant daily to coordinate plan of care. DON, Assistant Director of Nursing will communicate any new identified behaviors as well as interventions and orders with staff during daily huddle; staff will also be encouraged to report any new or unusual resident behaviors. Nursing managers will monitor daily for compliance. A reference behavior binder will be kept at the nurses' stations that contains identified residents sexually inappropriate behaviors. Care plans and interventions will be included. DON, ADON, Social Service and designee will maintain, and update binder as needed.iv. For residents with sexually inappropriate behaviors, behavior monitoring will continue every 2 hours times 2 weeks and every shift thereafter while awake by nursing staff and will be documented on behavior monitoring log. Findings will be escalated to abuse officer and DON for protocol implementation immediately.v. QAPI with the QA Committee and Medical Director was held on March 10, 2026, to discuss the plan of removal, Sexual Abuse policy the Management of Sexual Behaviors, this includes monitoring of behaviors such as sexual comments, sexual gestures, flirtatious behaviors, excessive friendly touching and/or directed infatuation of another resident; implementing interventions such as re-direction, firm limit setting, separation, escorting residents to a more closely supervised area, reality orientation, notification of appropriate responsible party/provider, and to ensure that all corrective actions and safety measures are consistently implemented.vi. Human Resources and Director of Nursing initiated a staff in-service and will continue to conduct ongoing in-services on Management of Sexual Behaviors, this includes monitoring of behaviors such as sexual comments, sexual gestures, flirtatious behaviors, excessive friendly touching and/or directed infatuation of another resident; implementing interventions such as re-direction, firm limit setting, separation, escorting residents to a more closely supervised area, reality orientation, notification of appropriate responsible party/provider. Staff to include dietary, housekeeping, therapy, nursing and administrative departments. Any agency staff will be educated prior to the start of their first work shift; education will be provided by the Charge Nurse and/or manager designee.4. Monitoring of Corrective Actionsa. A tool has been created in which the Administrator and/or designee will select 5 random residents weekly x 4 weeks to ensure that residents are free from abuse. Start: March 10, 2026; goal: April 7, 2026.b. Any quality assurance issue/s and progress will be reported to facility's monthly QAPI meeting for three months by the Administrator and recommendations given to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional months until Compliance is sustained.c. Administrator and/or Director of Nursing will complete monthly in-servicing on the facility's sexual abuse policy and sexual behavior management for three months and quarterly thereafter. Start: April 1, 2026.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review, the facility failed to follow fall prevention interventions for a resident who was a known fall risk.This applies to 1of 3 residents (R1) reviewed for falls in the sample of 6.The findings include:R1's EMR (Electronic Medical Record) showed R1 was admitted to facility on May 21, 2025, with the diagnoses of chronic obstructive pulmonary disease, hypertension, anxiety, metabolic encephalopathy, wedge compression fracture of fifth lumbar vertebra, disorders of bone density and structure, falling, fracture of lower end of left femur, atrial fibrillation, hypothyroidism, lack of coordination, urinary tract infection, and cirrhosis of liver.R1's MDS (Minimum Data Set) dated February 17, 2026, showed R1 was cognitively intact. The MDS continued to show R1 required maximal assistance from facility staff with toileting hygiene and moderate assistance from facility staff for transfer. R1's fall risk care plan dated May 21, 2025, showed [R1] is at risk for fall related to weakness, fatigue, activity intolerance, pain, history of falls. The care plan continued to show multiple interventions dated May 22, 2025, including Staff will assess and anticipate resident's personal and ADL (Activity of Daily Living) needs such as toileting, incontinence care, grooming, eating, catheter care, etc. during rounds. Staff will attend to needs as they are identified.R1's fall care plan dated July 21, 2025, showed [R1] has an actual fall. The care plan continued to show multiple interventions dated July 22, 2025, including Fall precautions: Bilateral safety mats; Staff to make frequent safety rounds to ensure needs are being met.R1's fall assessment dated on November 21,2025, showed R1's score of 20, indicating she was high risk.On March 9, 2026, at 11:50 AM, R1 stated she had a fall during the night on February 24, 2026, when she put on her call light because her incontinence brief was wet. R1 stated the CNA (Certified Nursing Assistant) answered her call light, R1 told her she needed to be changed, and the CNA said she would be back. R1 stated she couldn't wait any longer and needed to urinate so R1 attempted to get to her wheelchair to take herself to the bathroom and fell forward. R1 stated she used her cell phone to call the facility to notify the nurses she had fallen and needed assistance. R1 stated she sustained a skin tear on her left arm and told the nurse she was having back pain. R1 said she had pain throughout the night. R1 stated in the morning, V19 (pulmonary nurse) came to her room and asked R1 what happened. R1 stated she told V19 she had fallen the previous night. R1 stated V19 called the ambulance, and she was transported to the local hospital. R1 stated while in the hospital she had a surgical procedure for her back pain.On March 10, 2026, at 12:34 PM, V19 (Pulmonary Nurse) stated she assessed R1 on the morning of February 24, 2026, around 8:30 AM, and R1 did not seem like herself. V19 stated R1 is normally cognitively intact. V19 stated R1 had a protruding quarter sized hematoma on the right side of her forehead and a skin tear to her left arm. V19 stated R1 told V19 she had fallen last night. V19 stated she asked R1 if she was in pain and R1 replied, yes on her back. V19 said R1 was on anticoagulant medication and was sent out via emergency services.A progress note dated February 24, 2026, at 8:59 AM, by V19 showed This nurse was at bedside at 8:40 AM to give first pulmonary treatment of the day. At this time, resident confused. Mentation status, alert and oriented times one. Per resident, she stated she fell sitting on the side of her bed trying to help her mom. Vitals performed, within normal limits. Blood pressure 117/73, heart rate 78. Respiratory rate 20. No fever noted. Hematoma noted to right forehead and skin tear to left upper extremity. Notified Administrator and DON (Director of Nursing). Resident on [apixaban]. Sent out immediately via [Emergency Medical Services). DON notified nurse practitioner.On March 10, 2026, at 4:00 PM, V9 (CNA/Certified Nursing Assistance) stated she was R1's CNA on the night of February 24, 2026. V9 said was in the middle of getting ice water for another resident when V9 saw R1's call light was illuminated. V9 said she answered R1's call light and R1 said she needed incontinence care because she was wet, and all of her sheets were wet. V9 stated she told R1 she needed to complete a task another resident and would come back. V9 stated she continued to get ice water for the other (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents and took it to the resident and then V9 went to the linen cart and got some sheets for R1's bed, but there were no incontinence briefs so V9 had to go upstairs to get briefs. V9 said when she returned to the unit, the nurse told V9, R1 called the nurses station and said she fell. V9 stated when she arrived to R1's room, R1 was on the floor lying on her back and R1's left arm was bleeding.On March 10, 2026, at 3:50 PM, V2 (DON) stated R1 had an unwitnessed fall on February 24, 2026. V2 stated R1 had UTI (urinary tract infection) and was placed on transmission based precaution for UTI. V2 also stated R1 falls when she has UTIs.On March 12, 2026, at 1:26 PM, V2 stated it is the expectation for staff to follow the residents' care plan. V2 stated R1 is a resident for high-risk falls and staff should immediately attend to R1's needs, especially with incontinent care. V2 stated V9 should have immediately attended to R1 incontinence care needs instead of delivering water to another resident. V2 stated R1's incontinence care takes precedence and V9 could have waited to distribute ice water. On February 24, 2026 at the time of fall, R1 had a fall mat on the right side of her bed and didn't have the fall mat on the left side. V2 stated R1 fell out of the left side of the bed. V2 stated the bilateral fall mats were not in place at the time of R1's fall. V2 stated R1 should've had bilateral fall mats in place.On March 10, 2026, at 4:12 PM, V21 (R1's doctor) stated R1 had a fall on February 24, 2026. He stated she was sent to a local hospital the morning after her fall where an MRI (Magnetic Resonance Imaging) was conducted. V21 stated the MRI results showed a lumbar fracture, but it could not be determined if R1's lumbar fracture was acute or subacute. V21 stated he was aware R1 had a kyphoplasty for pain control during her hospital stay. V21 stated it is the expectation for staff to follow the facility's policy for falls, and to follow fall prevention interventions.The facility's policy titled, Policy: Fall Prevention and Management dated on October 29, 2021, showed Policy Statement: The facility is committed to its duty of care to residents and patients in reducing risk, the number and consequences of falls including those resulting in harm and ensuring that a safe patient environment is maintained.1. Fall Risk Screening.c. All residents and patients will be considered at risk for falling, regardless of risk score. Universal fall precaution interventions will be implemented to all. d. High risks residents and patients for falls will receive individualized interventions as appropriate to risk factors. 2. Fall Interventions: a. Universal Fall Precautions/Facility Fall Protocol will be implemented to all residents admitted to the facility regardless of risk scores.c. Fall Focus Program will be implemented to ensure purposeful rounding addresses residents positioning, pain, personal needs, personal items within reach, perils/safety hazards, and peaceful environment upon admission and throughout resident's stay. b. High Risk Precautions will be implemented to residents and patients whose scores on Resident/Family Notification Fall Risk screen shows high risk will be considered on this precaution. a. Universal fall Precautions/ Facility Fall Protocol will be implemented in addition to High-Risk Fall Precaution Interventions. b. Staff will remain with patient or resident when assisted to bathroom. c. Interventions will depend on identified and assessed risk factors, including root cause/s every after each fall or when a pattern has been identified. Some of these interventions may include but no limited to: .ii. Meaningful and or scheduled rounds.v. Assess need for toileting or incontinence care.