STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057380	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ORCHARD VALLEY	2330 WEST GALENA BOULEVARD , AURORA, Illinois, 60506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Complaint investigations 2566073/2576645 2564208/2576554 2569783/2576817	S0000		
S9999	Final Observations Statement of Licensure Violation 300.690a) 300.690b) 300.690c) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk	S9999		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057380	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ORCHARD VALLEY	2330 WEST GALENA BOULEVARD , AURORA, Illinois, 60506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 1 with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. These REQUIREMENTs were not met as evidenced by: Based on interview and record review, the facility failed to report and maintain reports of a serious incident to the Department and Regional Office for 1 of 1 residents (R2) reviewed for safety and supervision in the sample of 7. The findings include: R2's Progress Notes dated 2/17/24 at 10:27 PM show R2 was yelling out and staff found her on the floor beside the bed. R2 was on her left side and there was blood on the floor and R2's head. R2 was actively bleeding from her left upper forehead and a large, raised hematoma was noted to R2's forehead. R2 was sent to the hospital via Emergency Medical Services (EMS). R2's Progress Notes dated 2/18/24 at 9:20 AM shows R2 returned from the hospital via ambulance with facial swelling and bruising. R2's left side of her forehead had been repaired with skin glue and wound closure strips. R2's After Visit Summary dated 2/17/24 from the hospital emergency department shows R2 was treated for a fall and diagnosed with a fall and cut to her face. R2 had X-rays of her chest and pelvis. R2 was sent back to the facility with instructions on how to care for a face laceration with skin glue repair. On 7/28/25 at 1:09 PM, V5, former LPN (licensed practical nurse), said she does not know what happened to R2 (on 2/17/24). V5 said R2 returned to her care from the hospital with a lot of bruising to her face. V5 said R2 was a super confused resident and would call her daughter repeatedly and she would scream all the time. On 7/29/25 at 1:38 PM, V1, Administrator, said a formal investigation and report was not done regarding R2's fall from 2/17/24. V1 said any incident that requires staples or sutures, a major injury, a head injury, or an unusual occurrence needs to be reported to the state. V1 agreed that a resident who sustained a facial laceration which required repair should be reported to the state.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057380	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ORCHARD VALLEY	2330 WEST GALENA BOULEVARD , AURORA, Illinois, 60506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 2 The facility was not able to provide a file with a written report of R2's incident/fall from 2/17/24 or proof that it had been reported to the state. The facility's Fall Prevention and Management Policy (reviewed 11/3/21 and last revised 4/8/25) shows under Procedure for Post-Fall management other staff will be interviewed and a written statement will be completed. (C)	S9999		