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 09/18/2025

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: 2578563/2610646	S0000		10/01/2025
S9999	Final Observations Statement of Licensure Findings: 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)6) 300.3210t) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more	S9999		10/01/2025

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

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S9999	Continued from page 1 within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care 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. 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 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements are not met as evidenced by: 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	S9999		

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S9999	Continued from page 2 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 findings include: The Electronic Medical Record (EMR) shows R1 is a 79-year-old female resident admitted to the facility on March 3, 2020. 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 August 8,2025 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 56-year-old male resident admitted to the facility on November 30, 2024. 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 June 3,2025 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	S9999		

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S9999	Continued from page 3 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 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 actual 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,	S9999		

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S9999	Continued from page 4 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 knee level of R2's. V4 added that R1 was lying sideways facing the door and this meant R1 was facing R2. V4 said that she only saw R2 from behind, however, R2 pants was lowered all the way to his knee level and 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 report. V1 (Administrator) and V14 (Human Resources) were present during this 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, opened 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 say that R2 was known to be a wanderer, going into each residents' rooms, rummaging into residents' closets, and sometimes taking 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	S9999		

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S9999	Continued from page 5 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 standards 2-hour monitoring. They all said they do not know when that 1:1 staff supervision started but that it was started few days after the incident with R1 on August 29, 2025. On September 9, 2025, V1 validated that 1:1 supervision for R2 was initiated on September 8, 2025 at 6:00 A.M. This was 10 days later after the sexual incident that occurred on August 29, 2025. V1 also verified that 1:1 monitoring meant that staff had the visual control of R1 during the supervision. On September 9, 2025 at 2:10 P.M., V2 (Director of Nursing) said that staff providing 1:1 monitoring to R1 should have been documenting in a binder what was R1's specific behaviors and what interventions was implemented. Together with V2, the binder that was mentioned cannot be found. As confirmed with V10, CNA/sitter (on September 9, 2025 at 12:35 P.M.) and V13, CNA/sitter (on September 10, 2025 at 10:00 A.M.), they have stated that there was no binder that they were supposed to document, nor they were told what specific behavior and implementation they were supposed to do with R1. They said that "we just watch him." R2 was lying in bed with door closed when V13 was watching R2. V13 said the door was closed for "privacy." On September 9, 2025 at 3:19 P.M., V3 (Assistant Director of Nursing) stated that R2 was placed on 1: 1 supervision last winter due to an elopement incident.	S9999		

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S9999	Continued from page 6 V3 also said that the 1:1 monitoring was discontinued and does not remember when, but R1 was placed on the secured alarmed floor designated as the dementia unit. The care plan that was initiated August 31, 2024, showed R1's wandering behavior, standing by hallways, exit doors and interventions were for elopement. The intervention was revised on September 4, 2025, after the incident of August 29, 2025, which showed a non-specific intervention such as "increased rounding should resident's (R2) displays increased wandering behavior." On September 10, 2025 at 1:10 P.M., V16 (R1's family) said that she had received notification from V1 on September 5, 2025, regarding sexual abuse investigation that involved R1 and R2. V16 was dissatisfied why the facility did not notify her timely. V16 also said that facility only called the police 10 days after the alleged sexual abuse, and that possible evidence and securing perimeters for the alleged sexual abuse was already non-existent. On September 10, 2025 at 2:20 P.M., V19 (Clinical Manager for Hospice Care) said that based on R1's medical record for hospice care, the facility had not notified the hospice clinic, the hospice physician, hospice nurse, otherwise a hospice nurse could have visited and evaluated R1 immediately. The hospice record showed that R1 was seen by hospice nurse on August 28, 2025, September 4 and 8, of 2025 and there was no documentation existed regarding the sexual abuse allegation. On September 10,2025 at 2:31 P.M., V18 (Hospice Physician) validated that neither him, nor the alternating physician were not notified regarding the sexual allegation that involved R1. V18 added that if they would have known, they would have sent a hospice nurse immediately to assess, evaluate and provide treatments as indicated. On September 10, 2025 at 2:59 P.M., V22 (R1 and R2's Primary Physician) said that he was not notified of this sexual allegation that occurred and involved R1 and R2. V22 said that if he would have been notified, he would have sent R1 to the hospital for evaluation	S9999		

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S9999	Continued from page 7 and determine any trauma, STI (sexually transmitted infections) and should have sent R2 to the psychiatric hospital for psychiatric assessments, evaluations, and treatment. The facility's abuse policy dated October 24,2022 showed that "Residents have the right to be free from abuse… Abuse means any physical or mental or sexual assault inflicted upon resident other than by accidental means… sexual abuse in non-consensual contact of any type with a resident…. The facility prohibits abuse, neglect, exploitation of its residents including verbal, mental, sexual abuse…" "B"	S9999		