

Illinois Department of Public Health

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 03/17/2026	
NAME OF PROVIDER OR SUPPLIER PEARL OF ORCHARD VALLEY				STREET ADDRESS, CITY, STATE, ZIP CODE 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		S0000			03/23/2026	
	Investigation of Facility Reported Incidents of 2/9/2026/2785274						
S9999	Final Observations		S9999			03/23/2026	
	Statement of Licensure Violations:						
	300.610a)						
	300.1210a)						
	300.1210b)						
	300.1210c)						
	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 300.1210 General Requirements for Nursing and Personal Care						
	a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 the Act) 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. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to keep residents free from sexual abuse when 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. 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 87-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 81-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			S9999			03/23/2026

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S9999	Continued from page 2 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 July 6, 2015, 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 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 August 29, 2023, with multiple diagnoses including dementia, major depressive disorder, and anxiety disorder. R3's MDS dated December 22, 2025, showed R3 had moderate cognitive impairment. The MDS continued to show R3 exhibited wandering behavior for one to three days of the assessment period.			S9999			03/23/2026

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S9999	Continued from page 3 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			S9999			03/23/2026

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S9999	Continued from page 4 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 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			S9999			03/23/2026

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S9999	Continued from page 5 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/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..." 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			S9999			03/23/2026

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S9999	Continued from page 6 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, misappropriation of property, and exploitation of residents, including verbal, mental, sexual, or physical abuse; corporal punishment; and involuntary seclusion. The facility has a 'no tolerance' philosophy; persons found to have engaged in such conduct will be terminated. Definitions: ... Sexual Abuse is non-consensual sexual contact of any type with a resident... Protocol: Objective of Abuse Policy: the objective of the Abuse Prevention Program is to comply with the seven-step approach to abuse and neglect detection and prevention. The Abuse Prevention Program will			S9999			03/23/2026

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S9999	Continued from page 7 be reviewed on an annual basis or more frequently and will be integrated into the facility Quality Assurance And Performance Improvement (QAPI) program... V. Reporting and Response... E. Final Report and Follow Up. 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 mental 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, the 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.			S9999			03/23/2026

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S9999	Continued from page 8 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 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			S9999			03/23/2026

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S9999	Continued from page 9 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..." (B)			S9999			03/23/2026