STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145045	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Naperville, The	200 Martin Avenue Naperville, IL 60540

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff responded timely to residents' requests for care assistance and/or pain medication in accordance with their policy.This applies to 4 of 4 residents (R1, R2, R3, and R4) reviewed for call light response in the sample of 4.The findings include:1.On May 4, 2026, at 10:15 AM, V5 (Staffing Coordinator) stated she received a call from V6 (Agency CNA/ Certified Nursing Assistant) on April 29, 2026, at around 8:00 PM. V5 stated at the same time, she received a call from V7 (LPN/ Licensed Practical Nurse) who was working the 7:00 PM until 7:30 AM shift on April 29, 2026. V5 stated V6 was working, the 2:00 PM to 10:00 PM shift on April 29, 2026. V5 stated during the phone call with V6, V6 was talking loudly and raising her voice while complaining that V7 accused her of being on break for over an hour and not answering R1's call light for 59 minutes.V7 provided a written statement, dated April 29, 2026, that described how V7 was approached by V4 (Human Resources Director/Manager on Duty) on April 29, 2026, around 7:50 PM and was informed R1 had complained to V4 that R1's call light was unanswered for 45 minutes and R1 was requesting CNA (Certified Nursing Assistance) assistance to go to the bathroom. V7's statement showed the call light display board included a timer and 59 minutes had elapsed since R1 had activated his call light. R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE], with multiple diagnoses including paraplegia, unspecified, neuromuscular dysfunction of the bladder, neurogenic bowel, fusion of the thoracic spine and peripheral vascular disease. R1's MDS (Minimum Data Set), dated January 29, 2026, showed R1 was cognitively intact and required set up assistance from staff for eating, oral care, upper body dressing and rolling side to side in bed, partial assistance with footwear, coming to a standing position and transfer, and substantial assistance with bathing and toileting. On May 4, 2026, at 12:07 PM, R1 was observed in his room, up in his wheelchair, with a blanket covering his legs. R1 stated to surveyor, If you're from the state, I don't want to talk to you.On May 4, 2026, at 3:20 PM, V3 (ADON/Assistant Director of Nursing) showed the call light display boards and stated they are new and were installed around 6 months ago. V3 stated there were 2 call light display boards, one at each nurse's station, and the board alarms and displays which room the call light was activated from, and how long the call light has been activated, and updates the time at minute intervals. On May 4, 2026, at 3:26 PM, V12 (Licensed Practical Nurse/LPN) stated she worked on the 100 unit (where R1 resides) on April 29, 2026, 7AM-7:30 PM shift. V12 stated she did witness V4 approach the nurses' station and inform both V12 and V7 that R1 had complained he needed assistance to go to the bathroom and had been waiting with his call light on for 45 minutes. V12 stated she also observed V6 and V7 speaking loudly to each other near the nurses' station but was unsure if there were any residents present at the time. V12 stated she told both V6 and V7 to calm down before she left the facility. 2. R2's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE], with multiple diagnoses including cerebral infarction, unspecified asthma, anxiety disorder, and unspecified psychosis.R2's MDS (Minimum Data Set) dated March 5, 2026, showed R2 was cognitively intact, and required staff assistance with ADL's including set up assistance with eating and oral hygiene, supervision with personal hygiene, partial assistance with (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bed mobility sit to stand, transfer, upper body dressing and personal hygiene, substantial assistance with lower body dressing and bathing.R2 was identified as the Resident Council President on the meeting minutes dated April 9, 2026. The April meeting minutes showed an identified concern with call lights not being answered in a timely manner during the overnight shifts and call lights being turned off before the needs are met. On May 5, 2026, at 11:05 AM, R2 stated a concern was raised regarding call lights being answered timely on the overnight shift and stated she remembered R4 had raised the concern. R2 explained she had her own experience with call lights not being answered or being answered and the need not being met. R2 explained she waited for pain medication for an hour after her call light was on and the staff did not bring the pain medication. R2 could not recall the exact date and time when that happened. R2 further stated the call lights being answered timely is also a concern on weekends when there are more agency staff present. 3. R3 is was admitted to the facility on [DATE], with multiple diagnosis including Type 2 Diabetes, Lymphedema, Respiratory Failure, Morbid (Severe) Obesity, Obstructive Sleep Apnea, Chronic Diastolic (Congestive) Heart Failure, Essential Hypertension, Peripheral Vascular Disease, Venous Insufficiency(Chronic)(Peripheral), Abnormalities of Gait and Mobility, Muscle Wasting and Atrophy, Presence of Right Artificial Knee, and Iron Deficiency Anemia (chronic). R3's MDS (Minimum Data Set), dated April 16, 2026, showed R3 was cognitively intact. R3 requires supervision/touching assistance with eating, oral hygiene, and personal hygiene tasks. Substantial/ maximum assistance for upper body dressing, transferring to a sit to standing position, Chair/bed-to-chair transfer, and walking 10 feet. R3 was dependent on toilet hygiene, showering/bathing, lower body dressing, putting on/taking off footwear, bed mobility, transferring to a tub or shower and operating a wheelchair. On May 4, 2026, at 12:30 PM, R3 was sitting in the dining room in a wheelchair on his phone after eating lunch. R3 was dressed in appropriate clothing and footwear, well-groomed and free of odor. R3 stated when he uses his call light, it is not always answered in a reasonable timeframe, and his needs are not always met. R3 states this happens more when agency staff are assigned to work. 4. R4's EMR (Electronic Medical Record) showed R4 was admitted to the facility on [DATE], with multiple diagnosis including Acute Posthemorrhagic Anemia, Noninfective Gastroenteritis and Colitis, Gastrointestinal Hemorrhage, Essential (Primary) Hypertension, Hyperlipidemia, Hypothyroidism, Orthostatic Hypotension, Anemia, Adjustment Disorder, Unspecified Intellectual Disabilities, Diverticulosis of Intestine without Perforation or Abscess without Bleeding, Gastro-Esophageal Reflux Diseases without Esophagitis.R4's MDS (Minimum Data Set), dated April 3, 2026, showed R4 was cognitively intact. R4 requires set-up or clean-up assistance with eating, bed mobility, and using a wheelchair. Requires supervision or touching assistance with oral hygiene, toilet hygiene, upper body dressing, personal hygiene, transfers, walking with assistive device. And requires partial/moderate assistance with showering/bathing, lower body dressing, and putting on or taking off footwear.On May 5, 2026, at11:05 AM, R4 was identified as someone who complained about call light response times at the April 9, 2026, Resident Council Meeting minutes. Per the April Resident Council Meeting minutes, residents complained about call light response times on night shift. On May 5, 2026 at 11:28 AM, R4 was sitting in the lounge area in a wheelchair, while coloring. R4 was dressed in appropriate clothing and footwear, well-groomed and free of odor. R4 stated that once during night shift I had to wait for about an hour for someone to answer my call light. R4 stated it occurred on a Monday night, April 27, 2026. On May 4, 2026, at 3:55 PM, V1 (Administrator) stated the new call light display board had been installed about 6 months ago. V1 stated the call light display times are not stored and unable to be retrieved. V1 also stated he was unaware of any residents having to wait more than 45 minutes for their call light to be answered.On May 5, 2026, at 9:38 AM, V2 (Director of Nursing) stated the expectation for staff is to answer call lights as they pass by a room and if unable to provide for the residents' need, seek staff who are able to meet the need. V2 also stated waiting 45 minutes for a call light to be answered is an excessive amount of time to wait. The facility's policy titled Call Light Use, dated July 6, 2023, showed the facility aims to meet residents' needs as timely as possible, and the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	call light system is used to alert staff of resident's needs. The facility's policy titled Resident Rights-Exercise of Rights, dated January 17, 2025, showed, Intent: All activities and interactions with residents by any staff, temporary agency staff or volunteers must focus on assisting the resident in maintaining and enhancing his or her self-esteem and self-worth.while providing care and services, staff will respect each residents individuality, as well as honor and value their input.