STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145980	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of St Charles, The	850 Dunham Rd St Charles, IL 60174

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on observation, interview and record review, the facility failed to provide a resident with foot care. This applies to 1 of 3 residents (R1) reviewed for foot care in a sample of 3. The findings include:R1's Face sheet, dated 1/28/26, shows R1's diagnoses included Type 2 hemiplegia/hemiparesis, epilepsy, and Parkinson's disease. MDS (Minimum Data Sheet) dated 1/2/26, shows R1's cognition was severely impaired and R1 was dependent on staff for putting on and taking off footwear, lower body dressing, and showering/bathing and R1 required substantial/maximum assistance for personal hygiene. The MDS shows R1 had no skin problems at the time of assessment. Physician Order Sheet, dated 1/28/26, shows R1 had physician orders for daily skin check every night shift for prevention if moderate to high risk based on Braden scale and perform daily skin check if any skin issues are identified and a weekly skin check every Monday for his skin assessment. R1 also had physician orders for betadine paint/foam daily to be applied to his right foot daily and an order to apply house stock moisturizing lotion to both lower extremities as needed for dry skin. Podiatry note, dated 11/20/25, shows R1's right and left foot/ankle had dry/thin skin. The note shows R1's feet were to be kept clean and lotion was to be utilized daily. On 1/28/26 in R1's room, V3 (Nurse) stated R1 had no skin concerns or open areas on his feet. V3 removed R1's bilateral pressure relieving boots and socks. R1 had a brownish-orange waxy crust covering the majority of the bottom of his feet and spotty areas of the brownish-orange waxy crust were observed on the sides and top of his feet as well as his ankles and shins of his legs. There was also a large amount of brownish-orange waxy crust buildup between all of R1's toes and some of the areas were peeling away from R1's skin leaving pink, intact skin underneath. V3 examined R1's feet and stated she would clean R1's feet and call the wound nurse to examine the areas. V3 called the facility wound nurse and began to wipe R3's feet with a wet towel. Several small chips of the brown/orange waxy substance broke off and fell on the bed revealing intact, pink, dry skin. At 10:53 AM, V2 (Director of Nursing/DON) entered R1's room, examined R1's feet, and stated the waxy crust was not typically present on R1's feet and R1's feet looked very dry. V2 stated R1's feet should not appear to have the brownish-orange waxy substance and staff should be moisturizing R1's feet daily to prevent dryness. On 1/28/26 at 10:56 AM, V4 (Wound Nurse) arrived and examined R1's feet. V4 stated she applied cream earlier that morning. V4 examined R1's feet and stated his feet should be cleaned and lotions/creams should be applied. V4 stated the brownish-orange waxy substance was present on R1's feet for a long time prior and was not new. On 1/28/26 at 11:20 AM with V5 (Certified Nursing Assistant/CNA), V3 (Wound Nurse) washed R1's feet and chips of the brownish-orange waxy substance chipped off of R1's feet as she washed. V3 stated approximately 10-15% of the brownish-orange waxy substance was removed. V3 stated facility staff were expected to apply cream and ointment every day to R1's feet and wash his feet when providing a scheduled bed bath. V5 stated she did not wash R1's feet or apply lotion during AM care that morning. On 1/28/26 at 11:30 AM, V6 (CNA) stated the brown-orange waxy crust appeared on R1's feet intermittently. On 1/28/26 at 11:32 AM, V3 (Nurse) stated R1's feet were sometimes a bit dry, but she had (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145980	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of St Charles, The	850 Dunham Rd St Charles, IL 60174

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	never seen his feet have the brown-orange crust like observed that morning. V3 stated R1 usually had the crust between his toes and on the bottom of his foot. V3 stated the staff should wash R1's feet daily and not only during bed baths. On 1/28/26 at 11:45 AM, V2 (DON) stated R1's feet should not have had the brownish-orange waxy buildup to the extent see that morning and stated if she saw the buildup on R1's feet when applying lotion during AM care, she would have washed R1's feet to remove the buildup. On 1/28/26 at 12:47 PM, V7 (Nurse Practitioner) examined R1's feet and described the substance on R1's feet as an orange-brown waxy substance. V7 began to chip off the waxy substance on the bottom of R1's feet to reveal pink, dry, intact skin. V7 described the brownish-orange waxy substance as covering approximately 50% of the bottom of both of R1's feet. V7 stated the orange-brown waxy substance condition was preventable with daily foot care by washing and moisturizing R1's feet and the facility staff was expected to do daily cleaning and moisturizing to remove the built-up dead skin that was easily removable with a washcloth. V7 stated if build-up occurred like that observed on 1/29/26, the staff should have returned after R1's moisturizer absorbed and cleaned R1's feet to remove the buildup. V7 (Nurse Practitioner) progress note, dated 1/28/26, shows, the patient currently has dry, flaky skin to his feet; the skin is intact and no wound is noticed; the skin at the bottom of the foot is covered 50% with waxy and yellow looking dry skin which is easy to remove. Advised the skin care to the foot; clean with wet wash cloth and remove the dry skin buildup; apply moisturizer' reassess the foot to monitor for dry skin. Review of R1's Medication Administration Record, dated 1/1/26 to 1/31/26, shows R1's skin check was performed daily at 7:00 PM. Policy/Procedure Foot Care, dated 3/2025, shows, Procedure: To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: 1. Provide foot care and treatment, in accordance with professional standards of practice, including preventing complications from the resident's medical conditions.