STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146034	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl at the Tillers	4390 Route 71 Oswego, IL 60543

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on observation, interview, and record review, the facility failed to protect a resident from misappropriation of resident property when a staff member removed a resident's cellular telephone from the facility and later disposed of the cellular telephone in a trash receptacle at a local park. This applies to 1 of 3 residents (R1) reviewed for theft in the sample of 3. Findings include: The facility's final report to the State Survey Agency dated April 21, 2025 shows, Brief description of incident: R1 family stated R1's cell phone is missing from facility. R1 unable to identify any staff member that could be involved but an immediate search was completed. Disposition: R1's family called the facility and stated they have a phone tracking application downloaded on R1's phone and they were notified that R1's phone left the facility. R1's family retrieved the phone and returned it to R1. Upon interview with [V3] (CNA-Certified Nursing Assistant), she stated she accidentally grabbed R1's phone. [V3] stated she realized on her drive home that she had two phones and panicked. [V3] stated she was scared and threw the phone into a trash can at a nearby park. [V3] acknowledges she should have returned the phone to the facility, but she states she didn't know whose phone it was. [V3] apologized for her behavior The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE] with multiple diagnoses including, non-rheumatic aortic valve stenosis, difficulty walking, unsteadiness on feet, abnormal gait, COPD (Chronic Obstructive Pulmonary Disease), asthma, diabetes, morbid obesity, atrial fibrillation, congestive heart failure, heart disease, lymphedema, and osteoarthritis. R1's MDS (Minimum Data Set) dated April 1, 2025 shows R1 is cognitively intact, requires setup assistance with eating and oral hygiene, supervision with personal hygiene, partial/moderate assistance with showering and lower body dressing, and substantial/maximal assistance with toilet hygiene, bed mobility, and transfers between surfaces. R1 is occasionally incontinent of urine, and frequently incontinent of stool. (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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 28, 2025 at 10:03 AM, V1 (Administrator) said, [R1's] family had an app to track [R1's] cell phone. The app showed the phone left our facility between 3:10 PM and 3:15 PM on April 20, 2025. I looked at timecards and narrowed it down to who had just left the facility. The family tracked [R1's] cell phone to a trash can at a park. They went and retrieved the cell phone from the garbage can. [V3] (CNA) claims that she was burnt out and tired and she grabbed it and panicked and threw it out. On April 28, 2025 at 10:15 AM, R1 was sitting on the side of his bed. R1 was holding a cellular telephone in his hand. R1's cellular telephone had a heavy-duty, black protective case covering the telephone. R1 said he has had the protective case for his telephone for many years. R1 said, On April 20, I set my cell phone on my bedside table and went to lunch. When I came back, the cell phone was missing. I asked another resident to call my cell phone so I could find it. He called the cell phone, and we could not hear it ringing, so I knew it was missing. My family tracked the cell phone with the app on my phone and found it in a garbage can at the park, about two or three miles from here, and returned it to me. They told the facility, and they determined someone from here took my phone and then threw it away in the park a little while later. R1 continued to say he did not give anyone permission to use his cell phone. On April 28, 2025 at 10:56 AM, V6 (Daughter of R1) said, on April 20, 2025 her niece called to say Grandpa is missing from the nursing home. He is at some park close by. V6 continued to say the family did some quick investigating and found R1 was safely in the facility but his cell phone had been taken from the facility and then disposed of in the trash can at the local park. V6 said the facility did some investigating and found a staff member had taken R1's cell phone from the facility. On April 28, 2025 at 11:56 AM, V3 (CNA) said, It happened on a Sunday. I was overwhelmed and burned out and I didn't have anything to eat, and I was not feeling good, and I was running from room to room. I put the cell phone in my pocket. I didn't realize until I got home. It looked like my phone. My cell phone is black like [R1's] but does not have a protective case on it. I didn't know whose it was or where it came from even though, I had not been anywhere but work and my car to drive home. It would have been obvious that it was from work. I can't explain it. We are not supposed to take anyone's personal things. I stopped at a park and threw the cell phone in a garbage can. I should have returned the cell phone. I knew it had to be from work, I just didn't know where it came from. I know what I did was wrong. Facility documentation shows the local police department was notified. On April 28, 2025 at 6:42 PM, V7 (Police Officer) said he was the officer who responded to the call and investigated the incident. V7 said, [V3] admitted taking the cell phone and said it was a combination of panic and lack of time. [V3] admitted she threw the cell phone in the trash can. Had she just said she picked up the cell phone on accident and returned it to him, she would have been fine, but when she deprived [R1] of his cell phone by throwing it in the trash can, that shows intent to keep the phone from [R1]. The facility's undated Abuse Prevention Program - Policy shows, 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. Definitions: Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent.