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	04/09/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide timely incontinence care for residents who require extensive assistance for ADL (Activities of Daily Living). The facility also failed to assist a resident who is totally dependent on staff for transfers to get up to a wheelchair. This applies to 3 of 18 residents (R4, R57, and R63) reviewed for ADLs in the sample of 18. Findings include: 1. According to the EMR (Electronic Medical Record), R63 had multiple diagnoses, including Parkinson's disease, polyarthritis, other chronic pain, and encounter for attention to gastrostomy. R63's MDS (Minimum Data Set) dated March 23, 2026, showed R63 had severe cognitive impairment. The MDS also showed that R63 was dependent on staff for toileting hygiene. On April 4, 2026, at 9:12 AM, V17 (Certified Nursing Assistant/CNA) went into R63's room to perform morning care. R63 was lying in bed. V17 pulled back R63's covers and blankets, and there was a large amount of pasty and formed stool that had leaked out of R63's incontinence brief. R63's incontinence cloth pad was grossly soiled and saturated with brown stains, extending across the mid and lower portions of the incontinence cloth pad. The back side of R63's upper thighs was covered with stool. V17 said R63 was last checked for incontinence care during the last shift of CNA's rounds around 5:30 AM. R63's care plan, initiated on July 11, 2024, showed that R63 was incontinent of bowel. The care plan interventions included staff checking R63 as required for incontinence. On April 8, 2026, at 1:15 PM, V2 (DON) said CNAs are required to check residents every two hours for incontinence care. The facility's policy titled, Supporting Activities of Daily Living (ADL) with a review date of December 12, 2025, showed, Policy Statement: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. 2. The EMR (Electronic Medical Record) showed R57 was admitted to the facility on [DATE], with multiple diagnoses including cerebrovascular disease, type 2 diabetes mellitus, chronic kidney disease, unspecified dementia with other behavioral disturbances, congestive heart failure, obstructive sleep apnea. R57's MDS (Minimum Data Set) dated March 7, 2026, showed R57 was cognitively impaired. The MDS continued to show R57 was dependent on facility staff for toileting hygiene and was always incontinent of bladder and bowel. (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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R57's care plan dated February 13, 2026, showed R57 has impaired mobility due to decreased range of motion. Care plan continued to show R57 has an ADL self-care performance deficit, decreased self-bed mobility and requires assistance with toileting. On April 7, 2026, at 11:51 AM, V21 (family member) and V22 (family member) said they have found R57 lying in a soiled urine-soaked incontinence brief full of feces and in uncomfortable positions on multiple occasions. V21 and V22 said R57 had a CVA (Cerebrovascular Disease) so she cannot take care of herself and requires more assistance from staff related to toileting and ADLs (Activity of Daily Living). V21 said she found R57 lying flat on her back on multiple occasions in soiled urine-soaked clothing. V21 said while in room of R57 she noticed feces on the blanket of R57 and V14 took the blanket and threw it on the chair. V21 said she has been at the facility since 9 AM today and the CNA did not come in until 11 AM to provide a diaper change. On April 7, 2026, at 12:19 PM, V14 (Certified Nursing Assistant, CNA) said she came in at 6 AM for the start of her shift. V14 said she checked R57 at 6 AM and 8 AM and R57 was dry both times. V14 said she checked R57 again at 11 AM to provide incontinence care and saw stool and brown substances on blanket the size of her fist. On April 7, 2026, at 1:18 PM, V15 (Staffing Coordinator) said V14 (CNA) asked her to help change R57 she saw brown stains but did not know what it was. V15 said V21 and V22 were in the room during incontinence care. V15 said it was 11am when they provided ADL care for R57. On April 8, 2026, 10:17 AM, V2 (DON/Director of Nursing) said residents who are incontinent of bowel and bladder should be checked to see if they require incontinence care at least every two hours. V2 said R57 should have been provided with incontinence care sooner than over two hours, especially if brief was saturated and clothing was wet with urine. V2 said her expectation is for CNAs to provide incontinence care when residents are wet with urine upon rounds. The facility policy titled Supporting Activities of Daily Living (ADL) dated December 4, 2025, showed Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: 1. Hygiene (Bathing, dressing, grooming, and oral and nail care: .2. Mobility (turning, re-positioning, transfers, ambulation, including walking.3. Elimination (toileting). 3. R4's electronic medical record showed that she was admitted to the facility with diagnoses that included cerebral infarction, type 2 diabetes mellitus, abnormal posture, acute pulmonary edema, retention of urine, anxiety, and hypertension. R4's Minimum Data Set, dated [DATE], showed that R4 was dependent on staff for transfers. On April 6, 2026, at 11:04 AM, R4 was lying in bed and stated that the staff doesn't want her to sit up in a wheelchair because they think she will fall out of the wheelchair. R4 stated she would like to get up in the wheelchair. R4 stated it had been a long time since she was out of bed. On April 7, 2026, at 9:40 AM, R4 was observed lying in bed with television on. V16 (CNA) was getting R4's roommate up with a whole-body mechanical lift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 7, 2026, at 10:04 AM, at 12:36 PM, and at 2:20 PM, R4 was observed lying in bed. On April 7, 2026, at 3:19 PM R4 observed lying in bed and stated that no one offered to get her out of bed today. R4 stated she would have liked to get up during the day. On April 8, 2026, at 9:31AM, R4 was lying in bed with her television on. R4 stated no one has asked her if she would like to get out of bed. R4 stated she would like to get out of the bed and wheel down the hallway in her wheelchair. On April 8, 2026, at 10:07 AM, V27 (CNA) stated she has worked with R4 but has never gotten her up out of bed. V27 stated she charts (documents) when a resident refuses to get up out of bed, and she informs the nurse. On April 8, 2026, at 10:13 AM, V25 (CNA) stated R4 was alert and oriented and requires a whole-body mechanical lift to be transferred. V25 stated it is part of her routine to get residents up in morning. If the resident refuses to get out of bed, they tell the nurse and the therapist. V25 stated she has taken care of R4 but has never gotten her up into a chair. V25 started at the beginning of R4's stay at the facility over a year ago R4 used to get up, but she has not seen R4 up out of bed for at least the last 6 months. On April 8, 2026, at 3:57 PM, V16 (CNA) stated she has worked at the facility for 2.5 years. V16 stated she was assigned to care for R4 yesterday morning. V16 stated she got R4's roommate out of bed with a whole-body mechanical lift, and V16 stated, I did not ask her (R4) if she wanted to get out of the bed, and I know I should have asked her. V16 stated she did not get R4 out of bed yesterday. R4 stated in their computer system they document how a resident transfers, refusals, and is not applicable if the resident did not get up. On April 8, 2026, at 1:44 PM, V28 (CNA) stated that R4 requires a whole-body mechanical lift. V28 stated she has cared for R4 before but has never gotten her out of bed and has not ever seen R4 out of bed. On April 9, 2026, at 10:48 AM and at 11:09 AM, V2 (Director of Nursing) stated staff should be encouraging R4 to get up out of bed and ask R4 daily if she wants to get up. V2 stated they should encourage R4 to get up because it is R4's right to get up and socialize as part of activities and ADL care. V2 stated staff should be charting in the medical record if the resident refuses to get up. V2 stated the nurses should chart in the progress notes and EMAR (Electronic Medication Administration Record) and the CNAs should chart in the point of care tasks if the resident refuses to get out of bed. R4's progress notes and point of care tasks from March 9, 2026, to April 7, 2026, were absent of any mention of R4 refusing to transfer out of bed. Furthermore, R4's EMAR for March and April of 2026 showed the following: Monitor/record if targeted behavior of resisting care occurs every shift indicate if behavior occurred by indicating the number of times observed. There was no such behavior documented. The facility's Activities of daily living (ADL) policy dated December 4, 2025 showed the following: Appropriate care and services will be provided for resident who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with.mobility (turning, re-positioning, transfers and ambulation, including walking).