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	03/06/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 29562 Based on observation, interview, and record review, the facility failed to perform urinary catheter and perineal care in a manner that would prevent urinary tract infection (UTI). This applies to 2 of 3 residents (R13, R18) reviewed for incontinence and catheter care in the sample of 16. Findings include: 1. R18's Care Plan shows: R18 has an indwelling catheter due to obstructive uropathy. The same care plan shows multiple interventions which include the following: Catheter care provided during routine peri-care. Keep urine collection container below bladder level at all times to prevent reflux or stasis of urine. On March 4, 2025, at 1:34 PM, R18 was lying in bed which was wet with urine due to leaking indwelling urinary catheter. R18 stated that she has not been changed all day. On March 4, 2025, at 1:50 PM, V13 (Certified Nursing Assistant/CNA) provided perineal care to R18. V13 cleaned R18's peri-area but did not clean the indwelling urinary catheter tube. The anchor was almost detached from R18. As R18 turned on to her left side the anchor completely detached and the urinary bag slipped, and was hanging loosely at the foot of the bed, causing the catheter to pull during provision of care. While R18 was turned from side to side during provision of care V13 lifted the urinary bag multiple times above the bladder, causing some of the urine with sedimentation to backflow towards R18's bladder. The incontinence brief was saturated with urine which turned dark brown and had strong urine odor. V13 stated that she (V13) was busy the whole shift and she last checked R18 to see if she was dry at the beginning of her (V13) shift. 2. On March 5, 2025, at 9:35 AM, V13 and V14 (CNAs) provided incontinence care to R13 who was wet with urine and had a bowel movement. V14 wiped R13's outer labial in a downward stroke on the left and right side twice then she asked R13 to turn on her right side. V14 continued to clean the back peri-area. V14 completed the care without cleaning R13's abdominal folds, inner groin, and labial folds. (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
	146034	A. Building B. Wing	03/06/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 5, 2025, at 2:34 PM, V2 (Director of Nursing) stated that when providing peri-care the staff must clean from front to back. For female resident wipe the labia, labial folds, inner groins, pubic area, and abdominal folds to prevent a Urinary Tract Infection (UTI.) If a resident has indwelling urinary catheter the staff must clean/wipe the catheter tube near the peri-area away from the body, the tube must always be secured, the catheter must always be below the bladder to prevent backflow which can cause infection. Facility's Policy and Procedure for Perineal Care with review date of April 18, 2024, showed under intent, Perineal care is provided to clean the perineum, prevent infection and odors, and provide comfort. The same policy under guideline showed, 7. Ensure [indwelling] catheter is positioned correctly and secured. Wipe down tubing using downward stroke with a clean cloth. Support and secure tubing during procedure.

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	03/06/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 16746 Based on observation, interview and record review, the facility failed to evaluate and manage a resident's chronic pain. This applies to 1 of 1 resident (R26) reviewed for pain management in the sample of 16. Findings include: R26's Physician's (V5) progress notes dated November 22, 2024 showed that the resident has diagnosis of trigeminal neuralgia. R26's quarterly MDS (minimum data set) dated January 16, 2025 showed that the resident was cognitively intact. On March 3, 2025 at 10:24 AM, R26 was in bed, alert and oriented. While rubbing on her right cheek, R26 complained that she has nerve pain on the area. R26 stated that she last had her pain medication Tramadol at 9:00 AM and wanted to be given pain medication because she was still in pain. R26 scored her pain to be 8 out of 10 (10 being the worst). V15 (Registered Nurse) was notified of R26's complaint of pain. R26's active order report showed multiple orders including an order dated September 20, 2024 for, Gabapentin 100 milligrams (mg), to give 200 mg by mouth two times a day for nerve pain. An order dated December 23, 2023 for, Tramadol HCl (hydrochloride), to give 1 tablet by mouth every 6 hours as needed for moderate to severe pain and an order dated February 2, 2024 for, Acetaminophen 500 mg, to give 1000 mg by mouth every 8 hours as needed for pain. R26's medication administration audit report for March 3, 2025 showed that the ordered Gabapentin 200 mg for nerve pain scheduled to be administered at 9:00 AM, was administered at 10:31 AM by V15. This medication was administered after R26 was observed at 10:24 AM and one and a half hour after the scheduled administration time. On March 4, 2025 at 11:09 AM, R26 was in bed, alert and oriented. R26 was rubbing her right cheek and stated that she had pain. R26 scored the pain on her right cheek to be 10 out of 10 (10 being the worst). According to R26 she had received Tramadol medication between 9:00 AM and 9:30 AM. V4 (Licensed Practical Nurse) was immediately notified of R26's complaint of pain. At 11:10 AM, R26 told V4 that she has pain on her right cheek while rubbing the area. R26 again scored her pain to be 10 out of 10. V4 stated that R26, received her ordered Tramadol and Gabapentin that morning at around 9:30 AM. V4 offered Tylenol medication to R26 for her right cheek pain and the resident stated that Tylenol does not work to relieve her nerve pain. V4 offered to give R26 cold water but resident refused stating that her mouth hurts when she would open it. V4 told R26, that she (V4) will wait for 15 minutes and go back to the resident, to again assess the pain. (continued on next page)

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	03/06/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 4, 2025 at 11:30 AM, with V2 (Director of Nursing) present by the hallway, V4 was asked if she had re-assessed R26 for pain on her right cheek, since she stated that she will go back to the resident after 15 minutes to re-assess. V4 stated that she had not re-assessed R26 yet. V2 and V4 went inside R26's room. V2 asked R26 how she was doing, and the resident was observed rubbing her right cheek and verbalized that she was in pain. V2 asked the resident to score her pain and R26 stated 10 out of 10. R26 was again offered Tylenol, and the resident stated. It does not work for me. V2 stated that the facility will call the Physician to inform of the right cheek pain and to obtain any other additional orders. While walking out of R26's room, V2 was told that according to V4, the resident had received her ordered Tramadol and Gabapentin that morning at around 9:30 AM. V2 stated that V4 should have called the Physician earlier and did not have to wait to reassess R26's pain after 15 minutes when the resident complained of 10 out of 10 pain because the resident already verbalized not being relieved of pain after receiving her ordered medications earlier. R26's printed MAR (medication administration record) dated March 4, 2025 showed that R26 received her ordered Gabapentin at 9:00 AM. The March 4, 2025 pain assessment during the day shift showed a score of 10. The same MAR showed that the Tramadol 50 mg, one tablet was administered at 9:30 AM and there was no documentation of the effectiveness of the medication. The MAR was printed by the facility on March 4, 2025 at 10:38 AM. R26's progress notes dated March 4, 2025 at 9:30 AM showed that the Tramadol medication was administered due to face pain. R26's active care plan last revised by the facility on January 28, 2025 showed that the resident was at risk for alteration in comfort. With generalized aches and pains, and reported pain on her lower back, facial, and general aches and pains. The care plan showed that R26 was receiving scheduled Tylenol and as needed pain medication. The same care plan showed multiple interventions including, administering of medication as ordered and to monitor for effectiveness of relief and screen for pain when conversing with resident. On March 4, 2025 at 12:35 PM, V2 stated that if a resident complained of pain, ordered PRN (as needed) pain medication should be administered and she expects the nurses to reassess the resident for the effectiveness of the PRN pain medication, after 15 to 30 minutes, then document. V2 added that non-pharmacological interventions should also be offered such as positioning, ice pack or warm pack to be applied on the area. If the resident declined and the resident was not relieved of the pain after 15-30 minutes of administering the PRN pain medication post re-assessment, the Physician should be notified for further orders or any additional intervention, because the goal is to manage and/or relieve the resident of pain. V2 stated that when R26 complained of right cheek pain at 11:10 AM that morning, and after V4 offered to give Tylenol which according to the resident does not help, V4 should have called the Physician to obtain further orders, especially when R26 verbalized that her pain was 10 out of 10 on her right cheek, even though she had previously received pain medication (Tramadol) and Gabapentin at around 9:30 AM. According to V2 she spoke to R26's primary care physician (V5) about the resident's right cheek pain, at around 12:00 noon that day. V5 informed her that R26 had chronic trigeminal neuralgia, and that Tramadol pain medication does not relieve nerve pain. V2 stated that V5 increased R26's current scheduled order of Gabapentin from 200 mg twice a day to 300 mg twice a day and added an order to give Gabapentin 300 mg, right away as one dose for pain on the right cheek. (continued on next page)

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	03/06/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 5, 2025 at 2:24 PM, V5 (Physician) stated that R26 have chronic right sided pain on her face due to trigeminal neuralgia. V5 stated that R26 was started on a low dose of Gabapentin and had gradually increased the dosage due to the resident's complaint of increasing pain. According to V5, R26's trigeminal neuralgia pain cannot be completely rid of, because only surgery could help but because of R26's age, it was not recommended. V5 stated that Tramadol pain medication is not the recommended medication for nerve pain because it is not 100% effective and that Gabapentin is the effective and appropriate treatment to manage the increasing pain of R26 due to trigeminal neuralgia. According to V5, R26's action of rubbing the right side of her face probably meant that the pain was severe and to help manage the nerve pain on her face she ordered to increase the Gabapentin from 200 mg twice a day to 300 mg twice a day and also ordered to give one time dose of Gabapentin 300 mg on March 4, 2025 when she was informed of R26's 10 out of 10 pain on her right face. The facility's pain management policy last reviewed by the facility on December 17, 2024 showed, The facility shall provide adequate management of pain to ensure that resident's attain or maintain the highest practicable physical, mental and psychosocial well-being. The pain management policy showed in-part under procedure, 2. Behavioral signs and symptoms that may suggest the presence of pain include but are not limited to: . e. Bracing, guarding or rubbing. 3. Assessment and evaluation by the appropriate members of the interdisciplinary team may include: a. Asking the patient to rate the intensity of his/her pain using a numerical scale or a verbal or visual descriptor that is appropriate and preferred by the resident. b. Review of the resident's diagnoses or conditions and any additional factors that may be causing or contributing to pain. 4. If the resident's pain is not controlled by the current treatment regimen, the practitioner should be notified. 12. If when re-evaluation, findings indicate pain is not adequately controlled, revise the pain management regimen and plan of care as indicated.

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	03/06/2025

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 36567 Based on observation, interview, and record review, the facility failed to provide pureed corn bread as per planned menu to residents on pureed diets. This applies to 4 of 4 residents (R7, R15, R24, R273) reviewed for pureed diets in the sample of 16. Findings include: Facility Week at a Glance menu showed that the lunch meal for March 3, 2025 included Country Chicken and Dumplings, Glazed Carrots, Cornbread and Diced Pears. Facility Menu Extension sheet for pureed consistency included 2 #8 scoops of Country Chicken and Dumplings, #8 scoop of Glazed Carrots, #16 scoop of Cornbread, and #8 scoop of Diced Pears. Facility Dipper/Ladle Equivalents chart showed that #8= 4 fluid oz/ounce, #16 =2 fluid oz. On March 3, 2025 at 12:32 PM, the pureed meal preparation by V6 (Food Service Manager) was observed in the facility kitchen. V6 pureed the cooked Country Chicken and Dumplings first and then the cooked Glazed Carrots and transferred the items to pans to be placed at the steam table. During this pureed meal observation, the corn bread was not pureed. On March 3, 2025 at 12:41 PM, during meal service, R7, R15, R24 and R273 received 8 oz of pureed Country Chicken and Dumplings, 4 oz of Glazed Carrots, 4 oz of apple sauce (given on request). R7, R15, R24 and R273 did not receive pureed cornbread. V6 was made aware and he acknowledged that the pureed corn bread was not served. On March 5, 2025 at 3:20 PM, V11 (Dietitian) stated that she had originally worked with the menu's and signed off the adequacy of the same to provide daily nutrients for the day. V11 stated that the facility should provide the serving portions as shown on the spreadsheet or else the nutrition adequacy will not be met. V11 stated that the pureed cornbread provided the bread serving for the meal. The Facility resident listing of diet orders showed that R7, R15, R24 and R273 receive a pureed diet.

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	03/06/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36567 Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the facility kitchen and during meal service. This applies to 58 residents that received foods prepared in the facility kitchen. Findings include: The facility's Long Term Care Facility Application for Medicare and Medicaid dated March 3, 2025 showed the facility census was 59 residents. The facility provided information that there was one resident on NPO (nothing by mouth) status. On March 3, 2025 starting at 9:15 AM, during initial tour of the facility kitchen the following observations were made: The sanitizer bucket (that was placed on the kitchen counter) when tested with a QUART (Quaternary Ammonium) test strip by V6 (Food Service Manager), the test strip remained white color showing 0 ppm (parts per million) on the color scale of the test strip. V7 (Cook) stated that he had just filled the bucket a few minutes ago at the 3-compartment sink. V6 stated that V7 is new and that the color on the test strip should change from white to orange/green registering between 150-200 ppm. V8 (Dietary Aide) was at the dish machine washing dishes at the soiled side of the machine. The gauge on the dish machine showed between 150-155 degrees Fahrenheit at the wash setting and 130 degrees Fahrenheit at the Rinse setting. V6 who had come into the area confirmed that it is a high temperature dish machine. When asked why the rinse setting shows 130 and not 180 degrees Fahrenheit, V6 stated that the dish machine works fine and that it's the gauge that was not working. V6 added that the piping connection at the base of the dish machine was also loose, and he had notified the dish machine services regarding the same about a week ago. V6 stated that the facility uses the 180-degree test strips to test the sanitation of the high temperature dish machine. When a test strip was ran through the machine, the black line on the test strip turned dark gray and V6 gave the impression that since the color had changed, it was sufficient. V6 was showed the instructions on the test strip that the line should change from black to bright orange. On request, V6 sent the test strip once again through the dish machine and the test strip remained black. V6 was notified that the dishes that were just washed were not able to be used for meal service as there was no proof of the dishes being sanitized with the gauge not working and test strip not changing color. V6 stated that he will notify the services for dish machine maintenance. (continued on next page)

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	03/06/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On March 3, 2025 at 3:58 PM, V9 (representative of Dish Machine Service Company) was seen working on the dish machine. V9 stated that he was made aware a week ago about the loose drain body pipe at the base of the dish machine. V6 stated that during his visit to the facility thereafter, he noted that the drain body pipe was stripped, so the pipe will not stay connected long and that he placed an order for the same. V6 stated that the loose connection mainly affects the water drainage as the leaked water will seep into the dish area. V6 stated that he was not aware of the gauge not working. V6 stated that for high temperature dish machines, most facilities depend on the gauge to show that the temperature has reached 180 degrees Fahrenheit [for sanitation of the dishes]. Facility dish machine logs for breakfast, lunch and dinner for the past one week (February 24 to March 2, 2025) and March 3, 2025 breakfast recorded Wash/Rinse as 160/180 Fahrenheit. Signatures for most of these dates that were shown on the logs of these recordings were that of V10 (Dietary Aide). On March 3, 2025 at 4:01 PM, V10 stated that she starts at 8:00 AM. When V10 was asked how she recorded 160/180 when the gauge was not working during the past one week and whether the test strip had changed color during the dish washing procedure. V10 stated that she does not use the test strip and only looks at the gauge. V10 stated that she assumed that the temperature was 160/180 as she thought that it was the gauge that was not working and not the dish machine. On March 3, 2025 at 1:14 PM, two free standing carts with room trays were seen parked next to the nursing station. These carts did not have a cover over it and the dessert (fruit cup) was seen open to air. The tray card tickets showed that the meal trays belonged to R25, R29, R30, R69, R173, R174 and R274. Multiple staff and visitors were seen walking by the carts. V1 (Administrator) who was also walking past the carts was notified of the open carts. On March 3, 2025 at 1:17 PM, V6 stated that it is the responsibility of the dietary staff to cover the meal cart before delivery to the nurses station. On March 4, 2025 at 11:20 AM, the facility walk in Freezer (located outside) was noted to have ice built up over prepared foods stored in pans that were covered with a silver foil wrap. Parts of the silver foil on the pan were broken in showing ice seeping onto the food inside. There was ice built up on the floor at the base of these pans which included formation of a vertical shaft of icicle that was about a foot tall. These pans were inspected in presence of V6 and contents identified by V6 as follows: a large pan contained cooked ribs dated 12/16 (December 16, 2024), another pan contained bratwurst dated 1/17 (January 17, 2025), a pan contained fish that was completely covered with ice and no label was therefore visible. V6 stated that these dates were when the food was prepared. V6 stated that the recent weather fluctuations in the last two weeks triggered the condensations drips and ice built up. Facility Policy titled Cloths, Pads, Mops and Buckets (undated) included as follows: Policy: Cleaning tools will be maintained in clean, fresh, odor free condition. Procedure: 2. Cleaning cloths should be kept in a container of clean sanitized solution between uses. Facility Policy titled Sanitizer-Strength and Immersion Times (undated) included as follows: (continued on next page)

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	03/06/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procedure: 3. Quaternary Ammonium a. 150-200 ppm Facility Policy titled Dish machine Temp (undated) included as follows: Policy: Dishes, pots, pans, utensils, cups, mugs, bowls, etc will be washed using procedures, chemical and equipment that results in clean, sanitized items. Procedure: Machine Washing 3. Dish machine temperatures are logged at after each meal on the Dish machine Temperature Log. a. High temperature machine: Temperatures as required by the manufacturer. WASH 160, Rinse 180, Final Rinse 180-195. -If temperature reads incorrectly: Notify Department head and/or inform maintenance department (usually by work order form). - maintenance will determine if the malfunction is repairable -If unable to repair, maintenance will contact customer service company to schedule a date to properly restore operation of machine - If unable to repair dish machine by next mealtime the meal maybe served on disposable plates with plastic utensils OR the dishes and flatware maybe washed in the 3-compartment sink. Dishwasher temperature test strips for single use Food and Drug Administration (FDA) Food Code Compliance 180 degrees Fahrenheit/82 degrees Celsius included the following directions in summary: Attach the test strip to utensil or rack. Wash the item. If color bar has turned bright orange the dishwasher is maintaining the correct temperature. Facility Policy titled Freezers (undated) included as follows: Policy: Freezers will be defrosted monthly or as needed (when frost is 1/4 inch thick, freezer should be defrosted). Procedure: Remove all food from the freezer. Sort out and throw away all that is not usable .

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	03/06/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 29562 Based on observation, interview, and record review, the facility failed to follow standard infection control practices related to hand hygiene and gloving during provisions of ADL (activities of daily living) care. This applies to 2 of 16 residents (R13, R27) reviewed for infection control in the sample of 16. Findings include: Facility's Hand Hygiene Policy and Procedure with review date of June 2, 2024, showed, It is the policy of the facility to perform hand hygiene in accordance with national standards from the Centers for Disease Control and Prevention and the World Health organization. The same policy under procedure showed, Alcohol-based hand rub may be used for all other hand hygiene opportunities (e.g., when soap and water is not indicated) Hand hygiene is to be performed: .c. When moving from one contaminated body site to a clean body site such as when changing brief or wound dressing. d. After caring for a resident including after removing gloves. 1. On March 3, 2025, at 2:35 PM, V12 (Certified Nursing Assistant/CNA) performed perineal care to R27. V12 cleaned R27 from front to back, changed incontinence brief, repositioned R27, adjusted the pillow under his head, and the pillow under his lower extremities, and straightened his clothes, while wearing the same soiled gloves. On March 5, 2025, at 2:28 PM, V2 (Director of Nursing) stated that staff must perform hand hygiene and change gloves before starting care, from dirty to clean task, after care or before leaving the resident's bedroom, to prevent spread of infection. 2. On March 5, 2025, at 9:35 AM, V13 and V14 (both CNAs) rendered incontinence care to R13 who was wet with urine and bowel movement. V13 and V14 assisted R13 to wash her face and upper trunk and assisted in dressing her. After completing the task V14 removed her gloves, picked up the soiled items and carried it to the hallway without performing hand hygiene. On March 5, 2025, at 2:28 PM, V2 (Director of Nursing) stated that staff must perform hand hygiene and change gloves before starting care, from dirty to clean task, after care or before leaving the resident's bedroom, to prevent the spread of infection.