STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	**850 DUNHAM RD , ST CHARLES, Illinois, 60174**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Annual Licensure Survey	S0000		
S9999	Final Observations Statement of Licensure Violations 1 of 8: 300.610a) 300.615e) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act)	S9999		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 1 This requirement was NOT met as evidenced by: Based on interview and record review, the facility failed to review the CHIRP (Criminal History Information Response Process) within 24 hours of admission to the facility. This applies to 3 of 10 residents reviewed (R9, R14 and R15) in a sample of 23. Findings include: On 08/12/25 V2 (Director of Nursing) confirmed the facility census of 80 residents. R9's face sheet documents an admission date of 8/2/25. R9's CHIRP was completed on 8/4/25. R14's face sheet documents an admission date of 8/2/25. R14's CHIRP was completed on 8/4/25. R15's face sheet documents an admission date of 8/2/25. R15's CHIRP was completed on 8/4/25. On 08/13/25 at 09:50 AM, V14 (Director of Admissions) stated R9, R14 and R15 were admitted on a Saturday. V14 stated she ran the CHIRP for the residents on Monday when she returned to work. V14 stated she is the only person in the facility with access to run the CHIRP and was unaware it was required to be done within 24 hours of admission. The facility policy Resident Background Checks dated 6/15/2025 states when a resident is admitted to a facility, an electronic name-based UCIA (Uniform Conviction Information Act) background check must be ordered within 24 hours, unless the resident is admitted from the hospital and the hospital notified the facility that the UCIA name check was ordered. "C" Statement of Licensure Violations 2 of 8: 300.610a) 300.696d)14) Section 300.610 Resident Care Policies	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 2 a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.696 Infection Prevention and Control d) Each facility shall adhere to the following guidelines and toolkits of the Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, Agency for Healthcare Research and Quality, and Occupational Safety and Health Administration (see Section 300.340): 14)Implementation of Personal Protective Equipment (PPE) in Nursing Homes to Prevent Spread of Novel or Targeted Multidrug-resistant Organisms (MDROs) This requirement was NOT met as evidenced by: Based on observation, interview, and record review, failed to follow Enhanced-Barrier precautions (EBP) for residents. This applies to 3 of 3 residents (R5, R13, and R17) reviewed for infection control in a sample of 23. The findings include: 1.On 8/13/2025 at 10 AM, R5's room door had a sign for EBP during high-contact care. R5 had a gastrostomy tube (an indwelling medical device). R5 was in bed, and V3 (Certified Nurse Assistant/CNA) was rendering incontinence care to R5. V3 then proceeded to change R5's soiled linen and reposition him. V3 had gloves on but no gown when providing direct care to R5. R5's care plan reviewed on 8/13/2025, said R5 required EBP "to alleviate and reduce further spread of infection." 2. On 8/13/2025 at 10:15 AM, R13's room door had a sign	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 3 for EBP during high-contact care. R13 had a gastrostomy tube (an indwelling medical device). R13 was in bed. V4 and V9 (CNAs) were assisting R13 with dressing. They proceed to use a sit-to-stand mechanical lift to transfer R13 into her wheelchair. They had gloves on but no gown when providing direct care to R13. R13's care plan reviewed on 8/13/2025, said R13 required the use of a gastrostomy tube. R13's care plan did not indicate R13 required the implementation of EBP during direct patient care. R13's Order Summary Report dated 8/13/2025, had an order for "Enhanced Barrier Precautions due to history of ESBL." 3. On 8/13/2025 at 10:30 AM, R17's room door had a sign for EBP during high-contact care. R17 was in bed receiving wound care to his left lower leg. V3 (CNA) was assisting V10 (Wound Care Nurse) with positioning R17 during his wound care. V3 proceeded to reposition and change R17's linen. V3 had gloves on but no gown when providing care to R17. R17's care plan said he had a chronic open wound to his left calf. R17's care plan had an intervention for EBP for his wound initiated on 8/13/2025 (during the survey). R17's Order Summary Report dated 8/13/2025 had an order for "Enhanced Barrier Precautions due to: Wound" initiated on 8/13/2025. On 8/13/2025 at 1:15 PM, V2 (Director of Nursing/DON) said staff should be donning gloves and gowns when providing direct care for residents under EBP. V2 said she expected staff to adhere to EBP for the prevention of infection transmission. The facility's policy titled Enhanced Barrier Precautions dated 06/2025, said "Enhanced Barrier Precautions (EBP) is an approach targeted gown and glove use during high contact resident care activities, designed to reduce transmission of S. aureus and Multidrug Resistant Organisms (MDRO). EBP may be applied…to residents with any of the following: Wounds or indwelling medical devices…gown and gloves will be used during high-contact care activities. Examples…dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use…and wound care." "B"	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	**850 DUNHAM RD , ST CHARLES, Illinois, 60174**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 4 Statement of Licensure Violations 3 of 8: 300.610a) 300.1210d)2)4)A)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This requirement was NOT met as evidenced by:	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 5 Based on observation, interview, and record review, the facility failed to provide gastrostomy tube care, foot care, fall interventions, and ADL (activities of daily living) care for dependent residents. The facility also failed to order and provide ostomy care and interventions as directed by consulting outpatient practitioner. This applies to 11 of 11 residents (R7, R5, R9, R10, R11, R12, R13, R16, R17, R20, and R21) reviewed for nursing services in a sample of 23. The findings include: 1 On 08/12/25 at 12:00 PM, R7 stated she must cut a disposable undergarment and place it across her abdomen tucking it in the undergarment she wears to absorb the excessive amount of liquid stool that leaks out and burns her skin. R7 stated some staff that come to assist her are unaware of how to care for her ileostomy and will ask her for directions. R7 stated they don't have all the supplies that are needed to dress the ileostomy. V13 (Family Member) stated R7 was being followed by the wound nurse at the hospital, and he did not believe the directions were being followed since her skin around the ileostomy has been getting progressively worse. On 08/13/25 at 10:45 AM, V15 (Licensed Practical Nurse/LPN) stated she had just changed R7 thirty minutes prior to interview. R7's available supplies were reviewed with V15. No stoma-adhesive powder or ostomy belt was available. V15 stated R7 hadn't any order for Loperamide. R7 wafer (baseplate) appeared moist and was lifted at the right corner allowing liquid to leak out. R7's entire lower abdomen was reddened and excoriated. R7 was attempting to dry the drainage with a soaked tissue. On 08/13/25 at 11:41 AM, V2 (Director of Nursing/DON) stated the floor nurse caring for R7 should have access to all the supplies needed to care for R7's ileostomy. The nursing staff should have gotten orders to implement the hospitals wound nurse directions from her after visit summary. V2 stated the facility is responsible for providing the ordered supplies. R7's after visit summary dated 10/9/24 states to take Loperamide to decrease ileostomy output and hopefully prevent dehydration and keep watery contents from	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 6 contacting your skin. R7's after visit summary dated 2/4/25 ileostomy care instructions states: "Flexi- seal as recommended by skilled nursing facility RN (Registered Nurse) is not recommended or intended for use in a stoma. Do not leave pouch off. The stoma needs to be pouched in the following manner to maintain skin integrity. 1.cleanse skin with warm water 2.apply stoma-adhesive powder to any weeping areas; brush off excess 3.seal with no sting skin spray / wipe 4.repeat above using crusting technique 5. cut 2-piece 57 mm (millimeter) convex pouching system to 1 1/8". It is important the wafer is convex to help stoma protrude 6.ostomy belt to assist with stoma protrusion 7.change every 3 days Stretch surrounding skin flat prior to pouch application Use Loperamide as ordered by the surgeon to keep stool an "applesauce" consistency. Wound care RN please call with any questions / concerns / product questions." No order for ileostomy after visit care instructions were noted as written for R7. The facility policy Appointments and Transportation dated 04/16/25 states all consultation paperwork will be reviewed by the nurse and followed up as indicated. The facility policy Colostomy / Ileostomy care and Management dated 06/01/25 states follow all post operative assessments for new ostomies according to agency policy. 2. On 8/12/2025 at 10:50 AM, R5 was in bed connected to his gastrostomy tube feed via a pump. R5 was confused	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 7 and not able to be interviewed. R5's head was on a pillow and was positioned less than 30 degrees. R5's pump was alarming and not infusing. R5's infusion tubing was underneath him, and the pump said "inactive." R5's hanging (brand name) feeding bottle and tubing were unlabeled. R5's bed was also in a high position at approximately 2.5 feet from the floor. R5 had a fall floor mat on the right side of the bed, partially underneath his bed. At 12:20 PM and 3:10 PM, R5 was still in bed at the same height, and the floor mat was in the same position. R5 was still connected to his gastrostomy tube feed. R5's feeding pump was not infusing because it was turned off. On 8/13/2025 at 10 AM, R5 was in bed connected to his gastrostomy tube feed. R5's feeding pump was infusing. Then V3 (Certified Nurse Assistant/CNA) stopped R5's infusion to provide him with incontinence care. When V3 completed with R5's care, she resumed R5's infusion. R5's fall floor mat was still on the right side of his bed, partially underneath his bed. On 8/13/25 at 11 AM, R5 was still in bed in a high position. V10 (Wound Care Nurse/WCN) assessed R5's feet. R5's feet were unkept, they had a thick build-up of dry skin. V10 said R5 had a history of wounds, and his feet had to be monitored and moisturized daily for skin prevention. V10 said she had also referred R5 for routine podiatry care on 7/03/2025. R5's Order Summary Report dated 8/13/2025, had orders for enteral feed "(Brand name) 1.2 via feeding tube @ 75 ml/h with auto flush of 125 ml Q4hr. Up at 5PM, to run continuously until 1PM or TV of 1500 ml administered" and "HOB elevated at >45 degrees while tube feeding in progress." R5's Progress Note dated 7/25/2025 said R5's gastrotomy tube was clogged, and he had to receive services to replace his tube. R5's Podiatry Visit Note dated 7/03/2025, said R5's feet skin was noted to be dry and recommended facility follow skin hygiene protocol. The recommendations included keeping his feet clean, applying lotion, and assessing the skin daily. R5's care plan reviewed on 8/13/2025, said R5 required gastrostomy care as ordered. R5's gastrostomy interventions included administering tube feedings and flushing per the physician's order. R5's care plan also said he was at risk of skin breakdown and falls. R5's skin prevention intervention included using lotion	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 8 daily on dry scaly skin. R5's fall interventions included for staff to ensure the resident was properly and safely positioned in bed and for the bed to be in the lowest position. 3. On 8/12/2025 at 10:30 AM, R16 was in bed receiving her gastrostomy tube feed via a pump. R16's head was on a pillow and was positioned less than 30 degrees. R16's pump said it was infusing at 75 ml/hr (milliliters per hour) and had infused a total volume of 3094 ml. R16 said she felt sick to her stomach. On 8/12/25 at 12:15 PM, R16's head of the bed was at the position and still receiving her feeding. R16's feeding pump now said a total volume of 3214 ml had been infused. At 12:50 PM, R16's family member questioned V8 (Agency Licensed Practical Nurse/LPN) why R16's feeding was still infusing. R16's family member also informed V8 of R16's nutrition goal to eat orally. V8 said she was planning to allow the infusion to run till 2 PM because the prior nurse informed her the infusion was not administered as ordered. At 3 PM, R16 was still connected to her gastrotomy tube feed, but it was not infusing. R16 also had her served pureed lunch untouched on the bedside table. R16's Order Summary Report dated 8/13/2025, had an order for enteral feed "(Brand name) 1.2 via feeding tube at 75 ml/hour via feeding. Up at 1700, to run continuously until total volume of 1050 ml. Water Flush 100ml every 3 hours." R16's Progress Note dated 8/04/2025 said R16 was complaining of abdominal discomfort her gastrostomy tube had to be replaced. R16's care plan reviewed on 8/13/2025, said R16 required gastrostomy care as ordered. R16's interventions included administering tube feeding as ordered and elevating the head of the bed during and after tube feeds. On 8/13/2025 at 1 PM, V2 (Director of Nursing/DON) said she expected nurses to follow physician orders for enteral feeding infusions and flush to ensure residents received appropriate nutrition and prevent complications such as tube clogging. V2 said she also expected residents to be positioned safely in bed when receiving their feeds to prevent aspiration. V2 continued to say that only nurses were allowed to handle resident feeding pumps and should ensure feeding	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 9 sets and tubing are labeled properly for safe administration of tube feeds. The facility's policy titled Enteral Feeding dated 5/01/2025, said "It is the policy of the facility to provide adequate nutrition and hydration to ensure that residents attain or maintain the highest practicable physical, mental, and psychosocial well-being…The plan of care should address tube-feeding use, strategies to prevent complications…" 4. On 8/13/2025 at 10:30 AM, R17 was in bed. R17 was severely contracted and dependent on staff for his care. V10 (Wound Care Nurse/WCN) assessed R17's feet. R17's feet were unkept, they had yellow thick build-up of dry skin. V10 said R17 had a history of wounds to his feet, and his feet had to be monitored and moisturized daily for skin prevention. V10 said she had referred R17 for routine podiatry care because of his vascular conditions, but he was not seen. R17's care plan reviewed on 8/13/2025, said R17 was at risk of skin breakdown. R17's skin prevention intervention included using lotion daily on dry scaly skin. 5.On 8/13/2025 at 10:50 AM, R21 was in bed. V10 said R21 was at high risk for skin breakdown. V10 (Wound Care Nurse/WCN) assessed R21's feet. R21's feet were unkept, they had yellow thick build-up of dry skin. R21's right lateral heel had a dry callous with dry dark skin pigmentation. V10 said R21's feet had to be monitored and moisturized daily for skin prevention because of his diabetes. V10 said she had referred R21 for routine podiatry care, but he was not seen. R21's care plan reviewed on 8/13/2025, said R21 was at risk of skin breakdown. R21's skin prevention intervention included using lotion daily on dry scaly skin. On 8/13/2025 at 1 PM, V2 (DON) said she expected nursing staff to perform routine foot care as indicated in their plan of care to ensure proper resident skin prevention and management. The facility's policy titled Foot Care dated 03/2025, said "It is the policy of the facility to ensure it identifies and provides needed care and services that are resident centered, in accordance with the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 10 resident's preferences, goals of care and professional standards of practice…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 condition(s). 2. If necessary, assist the resident in making appointments with a qualified person…" 6. 8/12/2025 at 10:40 AM, R20 was in bed. R20 was confused and calling out. R20 had a specialty bed, which was in a high position. R20's bed was approximately 2.5 feet from the floor. R20 had a fall floor mat on the left side of the bed, halfway underneath the bed. On 8/13/2025 at 9:50 AM, R20 was in bed again. R20's bed was again in a high position with her fall floor mat in the same position. R20's care plan reviewed on 8/13/2025, said R20 was at high risk for falls because she had fallen out of bed on 6/06/2025. R20's fall intervention included the bed being in the lowest position with floor mats. On 8/13/2025 at 1 PM, V2 (DON) said she expected resident fall preventions to be implemented as indicated in their plan of care to ensure resident safety. The facility's policy titled Fall Prevention and Management dated 4/08/2025, said "The facility is committed to its duty of care to residents and patients in reducing risk, the number and consequences of falls including those resulting in harm and ensuring that a safe patient environment is maintained." 7. On 8/12/25 at 9:59 AM, R11 had hair on her upper lip and chain. She stated she would like to be shaved. R11's face sheet shows diagnoses of cerebral infarction, unspecified, need for assistance with personal care, other specified depressive disorders, and unspecified lack of coordination. R11's MDS (Minimum Data Set) dated 8/2/25 shows she is cognitively intact. R11 needs setup or clean up assistance with personal hygiene. R11's care plan (8/7/25) shows she requires assistance with ADLs	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 11 (Activities of Daily Living) related to weakness secondary to multiple complex conditions. 8. On 8/12/25 at 10:07 AM, R10 had a full thick beard. He stated that he wants to be shaved. R10 also had long fingernails with a black substance underneath them. R10 voiced that he wants them cut. R10 said that staff are too busy whenever he asks them. R10's face sheet shows diagnoses of adjustment disorder, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, and major depressive disorder. R10's MDS dated 6/27/25 shows he is moderately impaired in cognition. R10 needs set up or clean up assistance with personal hygiene. R10's care plan (6/14/25) shows he has an ADL self-care performance deficit needs and participations may vary related to weakness. 9. On 8/12/25 at 10:08 AM, R9 had long fingernails with a black substance underneath them. R9 stated he doesn't have clippers and wants them cut. R9's face sheet shows diagnoses of muscle weakness, unsteadiness on feet, and need for assistance with personal care. R9's MDS dated 8/6/25 shows he is cognitively intact. R9 needs supervision or touching assistance with personal hygiene. R9's care plan (8/11/25) shows he has an ADL self-care performance deficit related to his multiple cardiac issues. R9 has a history of being unable to care for self. 10. On 8/12/25 at 10:30 AM, R13 had fingernails that were long and dirty. R13 stated she would like them cut. R13's face sheet shows diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left dominant side and anxiety disorder. R13's MDS (7/30/25) shows she is cognitively intact. R13 needs partial or moderate assistance with personal hygiene. R13's care plan (7/26/25) show she requires assistance with ADL's due to having acute hemorrhagic stroke with right facial droop, dysphagia, and left-sided hemiplegia. 11. On 8/12/25 at 10:34 AM, R12 had a full thick beard. R12 stated he wants to be shaved. R12 stated he didn't know CNAs could shave for him. R12's care plan (8/12/25) shows he is at risk for alteration in skin integrity due to risk factors associated with weakness,	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 12 need for assistance with ADL's. On 8/13/25 at 9:01 AM, V2 (DON) stated, “CNAs (Certified Nursing Assistants) and nurses can assist with ADLs such as shaving and nail care when necessary. We usually shave during shower days or PRN (As Needed).” Facility's policy titled Supported Activities of Daily Living (12/5/24) shows: “2. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with c. hygiene (…grooming and nail care).” "B" Statement of Licensure Violations 4 of 8: 300.610a) 300.1630a)1)3) 300.1630b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1630 Administration of Medication a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 13 at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents. 1) Medications shall be administered as soon as possible after doses are prepared at the facility and shall be administered by the same person who prepared the doses for administration, except under single unit dose packaged distribution systems. 3)Self-administration of medication shall be permitted only upon the written order of the licensed prescriber. b) The facility shall have medication records that shall be used and checked against the licensed prescriber's orders to assure proper administration of medicine to each resident. Medication records shall include or be accompanied by recent photographs or other means of easy, accurate resident identification. Medication records shall contain the resident's name, diagnoses, known allergies, current medications, dosages, directions for use, and, if available, a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility. This requirement was NOT met as evidenced by: Based on observation, interview, and record review, the facility failed to follow physician orders, administer medications when prepared as ordered, and assess residents for self-administration of medications. This applies to 5 of 7 residents (R1, R8, R21, R22, and R23) reviewed for medications in a sample of 23. The findings include: 1. On 8/12/2025 at 12:30 PM, the facility's 500-unit medication cart had a clear medication cup with a loose orange capsule inside, unsecured and unlabeled. V8 (Agency Licensed Practical Nurse/LPN) said the capsule was R23's scheduled Gabapentin dose. V8 said she had removed R23's medication from its package and stored it in a medication cup to administer later. R23's Order Summary Report dated 8/13/2025, had an order for "Gabapentin Oral Capsule 400 MG Give 1 capsule by mouth three times a day related to EPILEPSY."	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 14 2. On 8/12/2025 at 12:30 PM, the facility's 500-unit medication cart had a clear medication cup with a loose white capsule inside, unsecured and unlabeled. V8 (Agency LPN) said the capsule was R22's scheduled Gabapentin dose. V8 said she had removed R22's medication from its package and stored it in a medication cup to administer later. R22's Order Summary Report dated 8/13/2025, had an order for "Gabapentin Capsule 100 MG Give 100 mg by mouth three times a day for neuropathy." 3. On 8/13/2025 at 9:15 AM, V7 (LPN) said she was going to administer R21's scheduled medications. V7's medication cart (500-unit cart) had a clear medication cup with three loose black round tablets, unsecured and unlabeled. V7 said the medications were Ferrous Sulfate 325 MG (milligrams). V7 said she had removed them from the house-stock bottle at the beginning of the shift. V7 proceeded to remove one black tablet from the medication cup and administered it to R21. R21's Order Summary Report dated 8/13/2025 had an order for "Ferrous Sulfate Tablet 324 MG Give 1 tablet by mouth one time a day for nutritional supplement" initiated 8/04/2025. On 8/13/2025 at 1:20 PM, V2 (Director of Nursing) said nurses were expected to administer medications as ordered once prepared. V2 said medications should not be removed from their original package and stored unsafely in the medication cart for later administration. V2 continued to say nurses were expected to follow the medication-rights, including the right dose, time, and drug to ensure safe administration of medications. The facility's policy titled "Medication Administration General Guidelines dated 11/2021, said "Medications are administered as prescribed in accordance with good nursing principles and practices…A. Preparation 3) An adequate supply of disposable containers and equipment is maintained on the medication cart for the administration of medications…4) FIVE RIGHTS-Right resident, right drug, right dose, right route, and right time…A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away…Select the medication…Prepare the dose…Complete the preparation of the dose and re-verify the label against	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 15 the MAR by reviewing the 5 Rights." 4. On 8/12/25 at 9:57 AM, on R8's bedside table there was a ProAir Respi-click (Albuterol Sulfate) inhaler. R8 stated it's always kept here on her table or in her purse. She said no one assessed her if she can safely use it. R8 said she's being using it for a long time. R8's face sheet shows diagnoses of unspecified asthma, uncomplicated, emphysema, unspecified, and COPD (Chronic Obstructive Pulmonary Disease), unspecified. R8's MDS (Minimum Data Set) dated 7/30/25 shows she is cognitively intact. Review of R8's electronic medical record shows in the POS (Physician Order Sheet) an order for the medication, but there was no order for it to be at the bedside. Under the assessments tab, there was no self-administration of medication assessment form uploaded. There was no care plan which indicates she can self-administer her inhaler. 5. On 8/12/25 at 10:15 AM, in a basin on R1's bedside table there were 2 tubes of Diclofenac Sodium 1% topical 100 Grams gel, 1 tube of Methylsalycylate Menthol (Muscle Rub) 15-10% 85 Grams, 1 tube of Diphenhydramine-Lidocaine 2% Aluminum +Magnesium, and 1 Bacitracin ointment. R1's face sheet shows diagnoses of other intervertebral disc degeneration, lumbar region with discogenic back pain only, restless legs syndrome, peripheral vascular disease, and age-related osteoporosis without current pathological fracture. R1's MDS (Minimum Data Set) dated 8/2/25 shows she is cognitively intact. Review of R1's electronic medical record shows an order for the Diclofenac Sodium gel, but there was no order for it to be at the bedside. There were no orders for the other medications and for it to be at the bedside. Under the assessments tab, there was no self-administration of medication assessment form uploaded. On 8/13/25 at 9:01 AM, V2 (DON) stated "We need orders from the doctor for medications from home and/or the hospital. We also need an order for it to be at the bedside." V2 stated that nurses must do a self-administration of medication assessment to see if residents can take the medication adequately.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 16 Facility's policy titled Self Administration of Medication Program (4/25/25) shows: "5. If a resident requests to self-administer drugs, it is the responsibility of the IDT (Inter-disciplinary Team) to determine that it is safe for the resident to self-administer drugs, before the resident may exercise that right. 7. The admitting nurse or designee will complete the Self-Administration of Medication Evaluation and report the findings to the Unit Manager or designee. 9. Once the resident has been deemed safe by the IDT, an order will be obtained from the resident's physician …listing the medication (s) that may be self-administered, where the medications will be stored, who will be responsible for documentation and the location of administration. 10. Appropriate documentation of the above determinations will be documented in the resident's care plan." "B" Statement of Licensure Violations 5 of 8: 300.610a) 300.1650a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1650 Control of Medications a) The facility shall comply with all federal and State laws and State regulations relating to the procurement, storage, dispensing, administration, and disposal of medications.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 17 This requirement was NOT met as evidenced by: Based on observation, interview, and record review, the facility failed to administer an anti-anxiety medication as ordered by the physician. The facility also failed to obtain the same medication from the electronic emergency kit and order the medication from pharmacy. This failure left R1 to not have the medication for 3 days which caused severe anxiety for the resident. This applies to 1 of 5 residents (R1) reviewed for medications in a sample of 23. The findings include: On 8/12/25 at 3:18 PM, R1 stated that she came to the facility on Saturday 8/9/25 in the evening. She stated she was anxious and asked the admitting nurse for her Ativan. R1 stated that the nurse told her she needed to order it from pharmacy and that she needed to wait. R1 stated, “I’ve been waiting 4 days now for my Ativan. I’m so anxious. My anxiety is up the wall. The nurses keep telling me that pharmacy hasn’t sent it. I don’t know what’s going on. This is ridiculous!” On 8/12/25 at 3:37 PM, surveyor asked V2 (Director of Nursing/DON) to open V11’s (Registered Nurse/RN) medication cart. There was no Ativan for R1 in the narcotic box. V2 went on her computer, and she confirmed that the Ativan was never ordered from pharmacy. She stated that there is an order in the POS (Physician Order Sheet) for the Ativan, but today it was changed to bedtime by the nurse practitioner. V11 stated that R1 told her if she could ask R1’s doctor to change her Ativan to be given at bedtime. V11 confirmed that she didn’t have R1’s Ativan in her medication cart. On 8/12/25 at 3:42 PM, V2 stated that the admitting nurse should have ordered the Ativan from pharmacy at the time of admission. V2 stated, “Since Ativan was ordered at the time of admission, the nurses could have got the Ativan from the (electronic dispensing system) and gave it to (R1).” R1’s face sheet shows an admission date of 8/9/25. R1’s face sheet shows diagnoses that include alcohol abuse, uncomplicated, cannabis use, unspecified, uncomplicated, other specified depressive episodes, and	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 18 anxiety disorder, unspecified. R1's MDS (Minimum Data Set) dated 8/2/25 shows she is cognitively intact. Hospital records indicate an order for Lorazepam (Ativan) tablet 0.5 MG two times daily PRN (As Needed). R1's current POS (August) shows that Lorazepam (Ativan) 0.5 MG (Milligrams) by mouth every 12 hours as needed for anxiety was ordered on the day of her admission 8/9/25. Review of R1's EMAR (Electronic Medication Administration Record) shows R1 never received Ativan from 8/9/25 to 8/12/25. Facility's policy from pharmacy titled Electronic Emergency Kit for First Dose and Emergency Medications (11/2021) shows the following: "Procedures: A. Electronic Emergency Kit (Pyxis) may be used by authorized facility staff to access first dose and emergency medications, per regulation and applicable law. Contents are property of the pharmacy, so authorization must be obtained prior to become available from the pharmacy." "B" Statement of Licensure Violations 6 of 8: 300.610a) 300.2100 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.2100 Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Code."	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 19 This requirement was NOT met as evidenced by: Based on observation, interview and record review the facility failed to maintain the kitchen in a manner that would prevent food borne illness. This applies to all 80 residents receiving nutrition from dietary services. Findings include: On 08/13/25 at 12:56 PM, V2 (Director of Nursing/DON) confirmed all 80 residents residing in the facility were receiving nutrition from dietary services on 08/12/25 when surveyors entered the facility. On 08/12/25 at 10:12 AM, the kitchen tour was conducted with V12 (Cook). The in-use dishwasher was run with a test strip that indicates temperatures up to 160 degrees Fahrenheit. The dishwasher final rinse gauge highest temperature was 176 degrees Fahrenheit. The sanitization level of one red bucket did not change color indicating the presence of sanitizer. Two green rinse buckets appeared murky and contained debris. Two kitchen drawers containing cooking utensils were greasy inside and had debris/crumbs. Three hanging rubber spatulas had burnt handles, gouges and missing chunks. The walk-in cooler contained a 24 oz (Ounce) energy drink and 16 oz bottle of water. Sliced turkey in a facility container with a single date of 8/10. Ham chunked and a few slices in a facility container with a single date of 8/10. Three gray hot dogs in a silver container with a single	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 20 date of 8/10. Tomato soup in a plastic facility container with a single date of 8/6/25. Six small bowls of tomato soup dated 8/6/25. Two clear pitches with yellow liquid without any labels or dates. One clear container with orange liquid and ice without any labels or dates. One blue pitcher with yellow liquid without any labels or dates. One 22-quart clear facility container with yellow liquid no label or dates. The reach in freezer contained: An accessed bag with contents identified by V12 (Cook) as sausage did not have any labels or dates Five boxes of mochi ice cream bites 7.5 oz in two bags from a local store. The kitchen table / shelving contained: A tray with 22 small containers of brown sticky substance was not labeled or dated. The covered meat V12 declared as clean had particles of food on it. The plate holder contained dishes with debris and smears. The dry storage contained: A 5 lb. (pound) bag of cornbread that had been accessed had a single date of 4/30/25 A 5 lb. bag of cinnamon streusel that had been accessed did not have any dates.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 21 A 5 lb. bags of brownie mix that had been accessed did not have any dates. A 5 lb. bag of brownie mix that had been accessed had a single date of 3/22/25. A 5 lb. bag of buttermilk pancakes that had been accessed did not have any dates. A 6lb 10 oz. can of yams was dented. A silver can without any label or date was dented. Signage posted in the kitchen read the only date that should be on food items is the use by date. On 08/13/25 at 11:18 AM, V16 (Dietary Manager) stated staff and activities food items should not be stored in the kitchen as it may cause cross contamination. Staff food should be kept in the breakroom refrigerator. Food items should be labeled with contents, in date, open date and use by date so that outdate food isn't being used or served to residents with allergies. Plates and dishes should be rewashed if they have food particles after being washed. They debris that remains on plates after being washed may cause a food borne illness. Broken spatulas shouldn't be used as they may break into food and pose a choking hazard. The green and red buckets should be changed out when they are dirty. The sanitization range should be 200 to 300 PPM (Parts Per Million). The dishwasher disinfects by temperature. The final rinse needs to reach 180 degrees to properly sanitize the dishes. The facility policy Staff Personal Food Storage dated 6/14/19 states food brought in by staff will be stored in designated areas only. The facility policy Labeling and Dating dated 7/30/23 states leftovers and opened food shall be clearly labeled with the date food item is to be discarded. The undated facility policy Storage of Dry Foods states the dietary department will store dry food used in food preparation in such a manner as to avoid contamination that optimizes food safety and quality. Dented cans shall be stored separately or immediately returned to the food vendor. If dented cans are stored in storeroom, they shall be clearly marked to prevent	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 22 usage. The undated facility policy Dish Machine Temp states dishes, pots, pans, utensils, cups, mugs, bowls, etc. will be washed using procedures, chemicals and equipment that results in clean, sanitized items. High temperature machine: temperatures, as required by manufacturer are wash 150-165. Final Rinse 180 – 195. The undated facility policy Cleaning Standards states food contact surfaces, non-food contact surfaces, equipment, pans, utensils, must be kept clean at all times. This includes but is not limited to free of grease deposits, food residue, dust and other soil accumulation / debris. "C" Statement of Licensure Violations 7 of 8: 300.610a) 300.2210b)1) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.2210 Maintenance b) Each facility shall: 1)Maintain the building in good repair, safe and free of the following: cracks in floors, walls, or ceilings; peeling wallpaper or paint; warped or loose boards; warped, broken, loose, or cracked floor covering, such	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 23 as tile or linoleum; loose handrails or railings; loose or broken windowpanes; and any other similar hazards. This REQUIREMENT was NOT met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain resident rooms in safe repair. This applies to 2 of 4 residents (R4 and R5) reviewed for physical environment in a sample of 23. The findings include: 1. On 8/12/2025 at 10:50 AM, R5 was in bed. R5's wall behind his bed was in disrepair. There was a large portion of the wall with a dent, causing the paint and drywall to come off. There was a moderate amount of accumulated drywall material and dust on the floor. 2. On 8/13/2025 9:45 AM, R4 said his room was in disrepair. R4's wall behind the room's door had an old, incomplete drywall repair with a new hole through it. R4 said the wall had been damaged and unrepaired for over a year. On 8/13/2025 at 11:40 AM, V6 (Operations Director) inspected R4 and R5's damaged walls. V6 said R4's damaged wall was a result of his exposed posterior headboard rubbing against the wall. V6 also said R5's unfinished, damaged wall had been there for a long time. V6 said the door continued to damage the wall because it required a door stopper. V6 said residents' rooms had to be maintained in good condition to ensure the safety of everyone, including the residents. The facility's policy titled Safe Environment dated 5/18/2025, said "It is the policy of the facility to provide a safe environment in accordance to State and Federal regulation…The facility will be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public." "C" Statement of Licensure Violations 8 of 8:	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	**850 DUNHAM RD , ST CHARLES, Illinois, 60174**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 24 300.610a) 300.2220a)1)2) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.2220 Housekeeping a) Every facility shall have an effective plan for housekeeping including sufficient staff, appropriate equipment, and adequate supplies. Each facility shall: 1) Keep the building in a clean, safe, and orderly condition. This includes all rooms, corridors, attics, basements, and storage areas. 2) Keep floors clean, as nonslip as possible, and free from tripping hazards including throw or scatter rugs. This requirement was NOT met as evidenced by: Based on observation, interview, and record review, the facility failed to have sufficient housekeeping staff to maintain residents' rooms clean. This applies to 4 of 4 residents (R5, R16, R4, and R18) reviewed for environment in a sample of 23. The findings include: 1.On 8/12/2025 at 9:50 AM, R18 was in her room. R18 said for approximately 10 days, the facility did not have enough housekeeping staff available to clean the residents' rooms. R18 said her room's floor had not been swept or mopped for over a week. R18's floor was	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 25 visibly soiled and had old food particles. On 8/13/2025 at 11:40 AM, R18 said her floor still had not been cleaned. R18's floor was visibly soiled with the same food particles. R18 said it made her upset to see her room unkept. 2. On 8/12/2025 at 10:30 AM, R16 was in bed receiving gastrostomy tube feeding infusion. R16's floor and wall near her feeding pump were soiled with splatters of dry feeding. On 8/13/2025 at 10 AM, R16's floor and wall near her feeding pump were still soiled with the same splatter of dry feeding. 3. On 8/12/2025 at 10:50 AM, R5 was in bed receiving gastrostomy tube feeding infusion. R5's floor and wall near his feeding pump were soiled with splatters of dry feeding. On 8/13/2025 at 10:15 AM, R5's floor and wall near his feeding pump were still soiled with the same splatter of dry feeding. 4. On 8/13/2025 9:45 AM, R4 said he was the residents' representative. R4 said he received concerns from residents who resided on the 500 and 600 units regarding their rooms not being cleaned for over a week. R4 said the facility had lost its housekeeping staff. R4 said his room had not been cleaned for over ten days. R4's floor was visibly soiled and had old food particles throughout. On 8/13/20225 at 11:40 AM, V6 (Operations Director) said all resident rooms should receive housekeeping services daily, including sweeping and mopping to ensure they have a clean environment. V6 said the facility had lost its housekeeping staff and was trying to hire more staff to ensure the facility was kept clean and safe, including resident rooms and common areas. The facility's document titled H2 Housekeeper dated 8/12/2025, said housekeeping daily tasks were for resident rooms to be cleaned, including wiping all surfaces, cleaning the bathroom, dust sweeping, and mopping floors.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF ST CHARLES, THE	850 DUNHAM RD , ST CHARLES, Illinois, 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 26 The facility's policy titled Housekeeping Deep Cleaning dated 7/25/2025, said “Residents are provided with a safe, clean, comfortable and homelike environment.” "C"	S9999		