STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145045	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Naperville, The	200 Martin Avenue Naperville, IL 60540

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 16746 Based on interview and record review, the facility failed to ensure a medicated patch was removed before another medicated patch was applied to prevent potential overdose of the medication. This applies to 1 of 3 residents (R1) reviewed for application of medicated patch/gel in the sample of 5. The findings include: R1 had multiple diagnoses including end stage renal disease, type 2 diabetes mellitus with diabetic chronic kidney disease, with diabetic nephropathy and with hyperglycemia, dementia without behavioral, psychotic, and mood disturbance and anxiety, based on the face sheet. R1's quarterly MDS (Minimum Data Set), dated July 3, 2024, showed the resident is severely impaired with cognition and required maximum assistance with most of her ADLs (activities of daily living). R1's order summary report showed multiple orders including hospice care, dated March 10, 2024, and Scopolamine transdermal patch, 1 mg (milligram) to be applied at bedtime, every three days for secretions, dated June 26, 2024. On July 29, 2024 at 4:53 PM, V7 (LPN/Licensed Practical Nurse) stated when V5 (daughter/POA [Power of Attorney]) was visiting R1, she was informed by V5 there were two scopolamine patches behind R1's ears, one on each side, and V5 took pictures. V7 does not remember the date of the incident, and she was not sure who was the nurse who she had endorsed the incident to. On July 29, 2024 at 5:12 PM, V2 (Director of Nursing) was asked if she was informed by the nurses or V5 about R1 having two scopolamine patches found behind the ears. V2 responded she was not aware. On July 30, 2024 at 8:56 AM, V2 stated she spoke to V9 (LPN) on July 29, 2024 after being informed by the State Agency personnel about the two scopolamine patches that were found behind R1's ears. V2 stated according to V9, she was informed by V7 that R1 had two scopolamine patches behind her ears, and V5 took pictures of it. V9 stated she had the two scopolamine patches behind R1's ears, had removed both of the patches and applied a new one. V9 does not remember when this double scopolamine incident happened. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On July 30, 2024 at 9:18 AM, V9 stated sometime early July 2024 (does not remember the specific date) while working her night shift (7:00 PM through 7:00 AM), she was about to apply a scopolamine patch to R1 at around 9:00 PM, when she noticed there were two patches of scopolamine behind the resident's ears, one on each side. V9 stated she removed both of the patches, cleaned the areas, and applied a new scopolamine patch behind R1's ear (does not remember which side) as scheduled, based on the order and MAR (medication administration record). V9 stated the nurse who was assigned to R1 prior to her discovering the two scopolamine patches was V7, who worked from 7:00 AM through 7:00 PM. V9 remembered that after finding the two patches behind R1's ears, she gave the report to the incoming nurse, who was again V7, about the incident and only during that time, V7 informed her V5 had shown her (V7) the two scopolamine patches on the resident's ears. According to V7, she was told by V5 (R1's daughter/POA) not to remove it, and that V5 had taken pictures of it. The facility presented a medication error report, dated July 30, 2024, which showed under nursing description, As per report the daughter reported to AM (morning) nurse that there are noted 2 scopolamine patch applied to each ear. Per nurse, daughter even took picture of the patches. The report showed under immediate action taken, Night Nurse remove the 2 scopolamine patch as per interview yesterday (July 29, 2024). Unable to recall the date. The same report showed the incident happened on July 5, 2024. Further review of the medication error report showed according to V7, who was the nurse on duty on July 5, 2024, R1's daughter had observed two patches of Scopolamine behind the resident's ears, and the daughter refused for her to remove the patches. The same report showed according to V9 (LPN), she does not remember the date when she noticed the two patches behind R1's ear. According to V9, she removed the two patches and applied a new one. On July 31, 2024 at 3:20 PM, V13 (Nurse Practitioner) stated for the scopolamine patch, it is expected for the nurse to remove the old patch before applying the new patch behind the ear of the resident. On July 31, 2024 at 3:40 PM, V14 (Pharmacist) stated before applying a new scopolamine patch, the old patch should be removed first because the said medicated patch has a residual effect even beyond the three days, and there is a chance that the resident could receive more dose of the ordered medication, if another patch is applied without removing the old one.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 16746 Based on interview and record review, the facility failed to discontinue the resident's IV (Intravenous) catheter as ordered, and failed to ensure that maintenance care of the IV catheter was performed and documented. This applies to 1 of 3 residents (R1) reviewed for IV (intravenous) catheter in the sample of 5. The findings include: R1 had multiple diagnoses including end stage renal disease, type 2 diabetes mellitus with diabetic chronic kidney disease, with diabetic nephropathy and with hyperglycemia, dementia without behavioral, psychotic, and mood disturbance and anxiety, based on the face sheet. R1's quarterly MDS (Minimum Data Set), dated July 3, 2024, showed the resident is severely impaired with cognition and required maximum assistance with most of her ADLs (activities of daily living). R1's progress notes, dated May 22, 2024 at 1:23 PM created by V16 (Nurse Practitioner), showed R1 was on hospice care with significant history of CKD (chronic kidney disease) and CHF (congestive heart failure). It was documented R1's labs showed AKI (acute kidney injury) on CKD. The progress notes showed R1's daughter spoke with hospice doctor and agreed for intravenous fluids. The same progress notes under assessment and plan showed one liter of intravenous fluid will be administered to the resident. R1's active medication report, which was provided by the facility on July 29, 2024, showed an active order, dated May 22, 2024, to administer 0.9 Sodium Chloride 1000 ml (milliliters) to run for 100 ml per hour via left brachial IV (intravenous) catheter. The same order showed, Start IV and discontinue IV when fluids are complete. R1's May 22, 2024 MAR (medication administration record) showed the IV infusion of Sodium Chloride 1000 ml was a one-time administration only for hydration. The same MAR showed it was started on May 22, 2024 and to be administered until May 23, 2024 at 5:00 AM. R1's progress notes, dated May 22, 2024 at 8:29 PM, showed an intravenous line was placed on the resident's left brachial and the 1000 ml of Sodium Chloride was being infused at the rate of 100 ml per hour. R1's progress notes, dated May 23, 2024 at 7:03 AM, showed the 1000 ml of intravenous fluid was administered to the resident at the rate of 100 ml per hour as ordered via the midline catheter on the left arm. Review of R1's progress notes for the month of May 2024 showed no documentation when the left midline catheter was removed. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On July 30, 2024 at 2:29 PM, V11 (RN/Registered Nurse) stated it was a couple of months ago (does not remember the exact date) when she received a call from hospice that R1's daughter reported the resident still had her midline catheter, even though R1's IV fluid had been completed for some time and there was no ongoing IV therapy. According to hospice, the IV line should be discontinued. V11 stated she removed R1's midline catheter the same day the hospice called after checking the order. V11 stated she remembered the order of the IV fluid and to discontinue the IV line when the IV fluid was completed. V11 admitted she did not document in the progress notes when she removed the midline catheter. The hospice notes, dated May 28, 2024, showed a call was placed to the facility at 10:45 PM, because the hospice received an email from R1's daughter reporting that resident's angiocath (peripheral vascular access) was still in place. It was documented the hospice nurse spoke to V11 (RN). The hospice notes showed according to V11, she did not know the angiocath was supposed to be removed, and V11 told the hospice nurse she will check the order and if she sees the order, she will remove it. On July 31, 2024 at 4:06 PM, V15 (Hospice Nurse) stated the IV fluid ordered for R1 on May 22, 2024 was a one time order for hydration, made by the hospice Physician and approved by the facility Physician or Nurse Practitioner. The order was to remove the IV line after the 1000 ml of Sodium Chloride was infused. On August 1, 2024 at 11:47 AM, V16 (Nurse Practitioner) stated when R1's laboratory results taken prior to May 22, 2024 showed the resident had acute kidney injury on chronic kidney disease, R1's daughter, who was very involved with the resident's care, wanted R1 to receive one liter of IV fluid. V16 stated on May 22, 2024, one liter of Sodium Chloride was ordered to be administered intravenously with the approval of the hospice Physician. V16 stated the IV fluid was ordered for hydration and kidney function. According to V16, R1 had ESRD (end stage renal disease) and CHF (congestive heart failure), and dialysis was recommended, but the resident and her daughter refused the procedure. V16 stated on May 22, 2024, IV fluid order was a one-time order, and after the one liter of Sodium Chloride was infused, the IV line should have been removed because there was no order to administer additional IV fluid. According to V16, giving more IV fluid to R1 will not help with the resident's ESRD, and it will make the resident's heart to work harder due to the extra fluids. On August 1, 2024 at 12:24 PM, V2 (Director of Nursing) acknowledged after the infusion of Sodium Chloride 1000 ml to R1 on May 23, 2024, the facility did not remove the midline catheter of the resident. According to V2, R1's midline catheter was only removed by V11 (Registered Nurse) on May 28, 2024, after receiving the call from the hospice nurse. V2 stated the removal of R1's midline catheter was not documented on the residents records including the progress notes. V2 stated that while the midline catheter was still in place and not in active use, the nurses should flush the catheter with 10 ml of normal saline daily, the nurses should measure the arm circumference and the external catheter length, and the appearance of the insertion site should be documented every shift based on the facility's standard IV infusion orders. According to V2, based on R1's records, there was no documented evidence the midline catheter was flushed with 10 ml of normal saline daily, there was no documented evidence the arm circumference and the external catheter length was measured, and there was no documented evidence the insertion site was monitored to ensure placement and patency of the midline catheter while not in use. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's pharmacy policy regarding flushing of midline catheter dated September 1, 2016 showed, Midline and Central Line IV catheters will be flushed to maintain patency. The policy showed under flushing protocol showed in part, 1. Flush catheters at regular intervals to maintain patency and before and after the following: e. Converting from continuous to intermittent therapies. The facility's standard IV infusion orders showed, Document insertion site appearance [every] shift and Midline measure arm circumference.