

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145045	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/05/2025
NAME OF PROVIDER OR SUPPLIER  Pearl of Naperville, The		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48308</p> <p>Based on interview and record review, the facility failed to ensure prescribed medications were available and administered in accordance with facility policy.</p> <p>This applies to 1 of 3 residents (R3) reviewed for medication administration in the sample of 9.</p> <p>The findings include:</p> <p>The EMR (Electronic Medical Record) showed R3 was admitted to the facility on [DATE], with multiple diagnoses including interstitial pulmonary disease, pulmonary fibrosis, polymyositis organ involvement unspecified, fracture of unspecified tarsal bones right foot, dysphagia, heart failure unspecified, difficulty walking, unspecified glaucoma, and essential hypertension.</p> <p>R3's MDS (Minimum Data Set), dated February 19, 2025, showed R3 was cognitively intact, and required assistance with ADLs including set up assistance with eating and oral hygiene, supervision with bed mobility side to side, partial assistance with upper body dressing, personal hygiene, substantial assistance with bathing, sitting up in bed, and dependent on staff for lower body dressing, toileting, and transfer.</p> <p>R3's physician order summary showed Mycophenolate Mofetil 500 mg. oral tablet give 3 tablets, 1500 mg every 12 hours ordered February 15, 2025. Dorzolamide HCL ophthalmic solution 2% instill 1 drop in left eye 3 times a day was ordered on February 15, 2025. Pantoprazole sodium delayed release 40 mg two times a day, give first dose at 6:00 AM, was ordered on February 16, 2025.</p> <p>R3's February 2025 EMAR (Electronic Medication Administration Record) showed Pantoprazole sodium extended release 40 mg was not documented as administered on February 21, and February 28, the 06:00 AM doses. R3's March 2025 EMAR showed Dorzolamide HCL ophthalmic solution 2% was not documented as administered because it was unavailable, on March 1st, 2025, at 9:00 PM, and March 2, 2025, at 9:00 AM dose and 5:00 PM. Mycophenolate mofetil 500 mg was not documented as administered because it was unavailable on March 2, 2025, at 9:00 AM.</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On March 1, 2025, at 12:38 PM, R3 expressed frustration regarding not receiving her medications as prescribed while in the facility. R3 stated she is well aware of what medications she takes, and stated she knows what medication to take and when to take it, because she took her medications herself when at home. R3 stated the facility runs out of her medication, even though she provides some of the medication she takes from home supply, and stated the staff have brought her the wrong medication and feels staff get upset with her when she won't take the medication being offered her because she knows the medication is not right.</p> <p>On March 2, 2025, at 6:20 PM, a medication cart audit was completed with V16 (Licensed Practical Nurse/LPN) to ensure medication ordered was available to be administered. R3's medication supply was missing 2 ordered medications, Dorzolamide HCL ophthalmic solution 2% and Mycophenolate mofetil 500 mg (milligrams), dose 1500 mg. V16 stated she did not administer either medication at the scheduled 9:00 AM dose, because the medication was not available. V16 also stated R3 told her this morning she did not receive her Mycophenolate mofetil last evening because the medication was not available.</p> <p>The facility's policy titled Medication Administration, dated April 18, 2024, showed, Guideline .14. Document as each medication is prepared on the MAR .18. If medication is not given as ordered document the reason on the MAR .19. If the medication is given at a different time, update the MAR to reflect administration time .21. If medication error is identified, notify MD/NP .24. If medication is ordered but not present, check to see if it was misplaced and then call the pharmacy to obtain the medication .</p>		