STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145689	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Elk Grove, The	1920 Nerge Road Elk Grove Village, IL 60007

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34491 Based on interview and record review, the facility failed to ensure a resident was not administered a medication that was not prescribed for them, and failed to notify the Director of Nursing, or a nurse manager, regarding a medication error in a timely manner for 1 of 3 residents reviewed for medication error in the sample of 8. The findings include: R1's Admission Record, printed by the facility on 8/15/24, showed she had diagnoses including Charcot's Joint, left ankle and foot, Covid-19, Type II diabetes mellitus, Methicillin Susceptible Staphylococcus Aureus infection (MRSA), and displaced comminuted fractures of shafts of left fibula and left tibia. R1's facility assessment dated [DATE] showed she is cognitively intact. R1's care plan initiated on 5/14/24 showed she is on diuretic therapy related to hypertensive heart disease. The care plan showed R1 was on Lasix and hydralazine. The care plan also showed that many other medications may interact with antihypertensive medications to potentiate their effect, and R1 should be monitored for interactions/adverse consequences. On 8/15/24 at 10:24 AM, R1 said about a month prior, an agency Nurse gave her the wrong medication. R1 said the agency nurse brought her medications in and they looked different. R1 said there was a capsule that was green and turquois-blue in color. R1 said she asked the nurse about the capsule and the nurse said she thinks it is an antibiotic that was prescribed for R1. R1 asked the nurse if she was sure and said the nurse told her yes, just take it. R1 said the nurse went out and came back to her room about five minutes later asking R1 if she took the medications. R1 said she told the nurse yes because she told her to. R1 said she asked the nurse why and the nurse said sometimes we make mistakes. R1 said she went to the dining room to visit with her daughter and started feeling nauseous. R1 said she started throwing up and she was dizzy, sweating, and had diarrhea. R1 said her blood pressure had dropped. R1 said she asked the nurse to give her a list of all the medications she gave her, but the nurse did not provide her with a list. R1 said she informed V4 (Registered Nurse-RN/Agency) about the incident and V4 went through the cart looking for a green and turquoise blue capsule. R1 said V4 found one that was the same as what the other agency nurse gave her and it was a medication for depression. R1 said one of the nurse supervisors went through the medication cart with her, and R1 pointed out the same medication. R1 said the nurse supervisor told her that was not one of her medications. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/21 at 1:32 PM, V3 (Licensed Practical Nurse/Infection Preventionist said R1 reported that she received a capsule that she was not familiar with. V3 said it happened on 6/22/24. V3 said there was a medication error, however, we could not figure out what medication it was. On 8/15/24 at 2:31 PM, V4 (Agency RN) said R1 reported the medication concern to me the same day that she said she got the wrong medication. V4 said R1 was being propelled down the hall in her wheelchair. V4 said R1 told him that she was not feeling well, and she thinks the nurse gave her the wrong medication. V4 said he looked through the medication cart and the only medication he could find like that was Duloxetine 60 milligram (mg) capsules. V4 said R1 identified the Duloxetine 60 mg capsules as the one the nurse gave her. V4 said R1 complained of feeling nauseous and dizzy so he took her into her room to help get her into bed. V4 said the nurse came in after that and said she would take over. V4 said the nurse denied giving the wrong medication. V4 said the nurse assessed R1 and updated the doctor. On 8/20/24 at 8:58 AM, V2 (Director of Nursing-DON) said V12 (RN) was the agency nurse working the PM shift on 6/22/24 when R1 said she received the wrong medication. V2 said she interviewed V12, and V12 did not remember which medication it was, or what the medication looked like. V2 said V12 told her R1 questioned her about the medication and V12 told R1 Okay, hold on, let me review your MAR (medication administration record). V2 said V12 told her she went out to check R1's MAR and when she returned, R1 had already taken the medications. V2 said she was informed about the incident on 6/23/24 when the nurse supervisor informed her. V2 said when she spoke to R1 about the incident, R1 told her it was a white capsule. V2 said she was not able to determine what the medication was that was given. V2 said she would absolutely expect the staff to call her when a medication error is determined. V2 said V12 should not have left the medications with R1. V2 said she educated V12 on that, as well as making sure she (V12) was following the physician's orders based on the eMAR (electronic medication administration record). V2 said V12 was terminated from the facility. When asked if it was because of the medication error, V2 said no. V2 said it was because V12 would wear her ear pods while working and was told several times to not wear them while working. At 1:35 PM, V2 said they have been telling staff if there is a medication discrepancy or concern to call her (V2) or a manager/supervisor right away. V2 said it is important to do this to start an investigation and for guidance on how to proceed forward. On 8/20/24 at 12:54 PM, V12 said there was no medication error. V12 said R1 asked what medications she was getting so she went out to check R1's MAR. V12 said she told R1 to let her go write it out for her. V12 said when she went back into R1's room, she had already taken it. V12 said R1 went off the unit for a couple of hours and came back complaining of nausea. V12 said she checked R1's vitals and her blood pressure was high. V12 said she had given R1 her blood pressure medication before she went off the unit. V12 said she gave R1 Zofran for her nausea, then updated the doctor. V12 said the doctor told her to continue monitoring R1 and update with any changes. V12 said she checked R1's blood pressure later and it was 93/47. V12 said she let the oncoming nurse know to monitor R1 for changes. V12 said she spoke with V2 prior to calling this surveyor back and V2 told her that she does not know why the facility DNR'd (Do Not Return) her. V12 said the agency told her that the facility said she was DNR'd due to a medication error. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24 at 11:16 AM, V10 (R1's Physician) said V13 (on-call doctor) was the one that took the call regarding the medication error involving R1. V12 said if there was a real medical emergency, V13 would have had R1 sent out to the emergency room . V10 said she would call and speak to V13 and call back. At 11:40 AM, V10 said V13 does not recall what medication was reported as given in error, or any special concerns associated with the call. V10 said R1's blood pressure had fallen from 160's-170' to below 100, however she had received her blood pressure medication and that would cause it to go down. V10 said R1 also had lab work done that showed she had a low hemoglobin level and a high potassium level. V10 said R1's symptoms could have been due to her potassium and hemoglobin levels. R1's Progress note dated 6/22/24 at 9:24 PM, showed Patients blood pressure was 166/82, hydralazine given as ordered. Patient came back after two hours complaining of nausea. Blood sugar was 162. Blood pressure was rechecked 178/88. Pulse 103. Respiratory Rate 19. Oxygen 95%. Zofran was administered as ordered. MD was notified with an instruction to recheck the blood pressure since Zofran has been administered already. Will continue to monitor. R1's 6/22/24 progress note at 10:39 PM showed Patient blood pressure is 93/47. Pulse 97. Oxygen 96% at room air. Patient denied any form of nausea or discomfort at this time. Will continue to monitor. R1's Progress note dated 6/23/24 at 1:11 PM showed Called and spoke with (V13) on call for (V10) regarding the med (medication) error and reactions happened yesterday and patient's current status. Patient states feels fine today. NNO (no new orders). The facility's incident report dated 6/23/24 showed R1 stated she was given a medication the prior evening that was new to her. Nurse on duty came back to her and told her that was not her medication but R1 had already taken the medication. Patient felt anxious, increased blood pressure, and vomited. The report showed the nurse on duty reported that patient verbalized she received a medication yesterday that she was not familiar with and requested the nurse to look up the medication for her. The report showed the patient had already taken the medication. The facility's policy and procedure titled Medication Administration, with a review date of 4/18/24, showed 1. An order is required for administration of all medications .5. Check medication administration record prior to administering medication for the right medication, dose, patient, and time. 6. Read each order entirely. 7. Remove medication from drawer and read label three times; when removing from drawer, before pouring and after pouring .14. Document as each medication is prepared on the MAR. 15. Identify resident using two resident identifiers. 16. Explain procedure to resident and give the medication. 17. Remain with the resident to ensure that the resident swallows the medication .21. If medication error/s identified, notify MD/NP (Doctor/Nurse Practitioner).