STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145748	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montgomery Place	5550 South Shore Drive Chicago, IL 60637

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review the facility failed to ensure that one resident R2 was free of medication error. This failure affected 1 of 3 residents reviewed in the facility.On 06/22/2026 at 1:55 PM, R2 was observed in bed. On the door the names that were labeled read R5(A), R2(B). When surveyor entered the room and observed the bed B empty, the resident in the first bed asked me who I was looking for and stated she was R2 and that R5 had discharged home. R2 stated she feels safe in the facility despite receiving the wrong medication from a nurse a few weeks ago. R2 stated that the nurse entered her room and gave her a cup of pills that she took. Then a few moments later the nurse returned back and said that she had pills for R2, when I stated to the nurse that you already gave me pills that is when the nurse said oops, I thought you were R5 because the way the door is labeled. R2 states she is only here temporarily for therapy and will be going back home and she has not seen that nurse since.R2 stated after receiving the wrong medications she was feeling tried and drowsy for a few days.R2 instructed me to speak with her daughter further related to the wrong medication administration. R2's face sheet dated 06/23/2026 documents, in part, readmitted to facility on 05/07/2026 with diagnoses of anemia, diabetes mellitus, idiopathic aseptic necrosis of right femur, fracture of rib on left side, pleural effusion, hypertensive heart, heart failure, chronic kidney failure, atrial fibrillation, muscle weakness, cognitive communication deficit, history of falls, obstructive sleep apnea. R2's Minimum Data Set (MDS) for Cognitive Patterns dated 05/13/2026 documents, in part, R2's Brief Interview for Mental Status (BIMS) score is 13, indicating cognitively intact.R2's Care plan dated 04/07/2026 documents in part that R2 is at risk for decreased cardiac output[Intervention: staff to monitor R2 for orthostatic blood pressure and if positive, alert physician, evaluate blood pressure, evaluate for change in level of consciousness, evaluate heart rate, evaluate pulse oximetry].On 06/22/2026 at 2:02 PM,V6 (Licensed Practical nurse) stated she is the nurse for R2 and that R2 is alert x 4 and able to make all needs known to staff. V6 stated when she came to work on 06/08/2026 V13(Occupational therapy assistant) informed her that R2 told her she received the wrong medication and she immediately informed the V2 (Director of Nursing). V6 stated she was not the nurse that performed the medication error but that she monitored the patient closely during her shift and observed that R2 was having altered mental status which she relayed to the physician and received orders for urinary culture. V6 did not document in medical record a blood pressure or vitals for R2 on 06/08/2026. V6 stated she is not sure if the medication error contributed to R2's change in condition, but after a medication error administration R2 should be monitored for three to seven days and documentation should be done.On 06/24/2026 at 11:43 AM,V13 (Occupation therapy assistant) stated on 06/08/2026 she was providing room therapy to R2 and R2 reported that she was not feeling well because she received the wrong medication on 06/06/2026.V13 stated she clarified with R2 that she meant that the medication she received was not for R2,at that point V13 went and got the nurse V6. V6 came into the room and asked R2 the same questions about the medications being administered to her that were not for R2 and that is when V2 entered the room.V13 stated that she observed R2 with tremors that was different from any other time she had provided therapy to R2.On 06/23/2026 at 2:50 PM, V15 (Registered nurse) stated she has been working at the facility through agency staff for over one year now.V15 stated when she started a year ago the names on the door (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were confusing to her because the way the doors are labeled, bed two is actually bed A and bed one is bed B.V15 states she uses other residents identifier to identify a resident such as photo in chart, wrist band if they have one or ask another staff member.On 06/23/2026 at 11:02 AM, V11(Registered nurse) interview on phone . stated the medication error occurred on 06/06/2026 on a Saturday evening. V11 stated she worked 7pm-7am on 06/06/2026 and she went into the room of R2, V11 stated she called out for R5's name 3 times and then R2 answered, R2 did not have on wrist band. V11 stated that the resident's door name tags are confusing because R2(B) and R5(A). V11 stated after R2 swallowed the medication that is when R5 woke up and stated she was R5. V11 stated that R5 told her she was confused and that is why she responded to R5's name but at that point it was too late because she has swallowed the medications already. V11 stated she informed R2 to let her know if she was having a change in condition to inform V11. V11 stated she completed an assessment on R2 and monitored R2 over the night. V11 stated she did not call the physician on call or use the facilities on call physician service because she was capable of monitoring R2 and that R2 was fine. V11 stated that since R2 did not require hospitalization then she would have called the doctor.V11 stated she attempted to reach V2 but there was no answer and no message was left.V11 stated she informed R2 to call her daughter and inform her of the medication error because she didn't think to call the family and no number was in chart. V11 stated there is no supervisory staff over the weekend available. V11 stated she was in contact with the facility on Monday, 06/08/2026 by V2 who informed me to send her a text message of what occurred on 06/06/2026. V11 stated that R2 has no adverse reaction and vital signs were fine and she felt that the medications would not cause any harm. V11 stated she did not complete a medication error report. V11 stated that V2 called her on 06/22/2026 (the day the surveyor entered the facility) to inform her that her employment status was being placed on open window status from 06/06-07/06, she did not call it a suspension but told me that I could not pick up any shifts at the facility within that time frame.On 06/23/2026 at 11:54 AM, V12(Family of R2) stated when she came to visit R2 on 06/08/2026,R2 informed her that she was given the wrong medication by a nurse, V12 stated R2 was shaking at that time so she informed the nurse she needed to speak to V2. V12 stated V2 informed her she has to investigate and track down who was the nurse. On 06/09/2026 V12 stated she spoke with V2 and informed her that R2 has on two name badges on her wrist and also the photo is on the computer. V12 stated she told V2 that R2 has a pacemaker and kidney issues and that she was informed by her primary care physician that R2 should not receive more that 200mg Gabapentin daily. V2 informed V12 that the staff would receive in-service regarding medication error and that V11 would be suspended. V12 stated she has asked several times for the incident report and the nurse documentation. V12 stated what if R2 had a stroke. V12 said R2 told her V11 stated oops, I gave you the wrong medications. V12 stated that V2 informed her that the medication error was that R2 only received multivitamins that she was not prescribed.On 06/23/2026 at 12:48 PM, V2 stated she is not sure what date and time she informed the NP/MD because she did not chart it. V2 stated her expectations of the nurse is to notify the family, physician and place an incident report in the system. V2 stated the nurses should monitor and document for 72 hours the condition of the patient and contact physician for any further orders. V2 stated she was not familiar with the on call video physician system but she thinks that is who the nurses are to contact. V2 stated she should have documented. V2 stated that her number is not placed in the electronic system or at nursing's station and there are no steps posted on how to complete an incident report at the nursing station. V2 stated she contacted V12 on 06/09/2026 but was not sure of the time because she did not document the conversation. V2 stated even if she would have charted the nurses would not follow up with charting because they are not good about charting at this facility. V2 stated that V11 has not been back to the facility since incident occurred and that she called V11 on 06/08/2026 after discovering she was the nurse who performed the medication error. V2 stated there was no documentation in the medical record of R2 related to medication error or monitoring from time of incident. V2 stated that she was made aware of the incident from V6 on 06/08/2026. V2 stated that (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition which is undated documents in part that; Intent: The purpose of this policy is to ensure the facility promptly informs the residents' physician and notified residents representative when there is a change requiring notification. Situations requiring notification include: 1)accident involving the resident which has the potential to require physician intervention.4).upon identification of a change in condition in a resident the nurse will complete an evaluation of the resident's status and document the findings on the change in condition form in the resident's electronic medical record.Facility policy titled medical errors occurrence reporting which is undated documents in part ; Intent: It is the policy of the facility to evaluate any concerns related to medical and or medication errors. Procedure: 1). In the event that a medication error is detected, the individual detecting it will complete the medication variance event form.3). The completed medication error occurrence record will be reviewed the next business day by the signed risk manager, administrator and director of nursing. 4). The completed medical error occurrence record will be reviewed by the medical director. Point of emphasis: all errors will be reviewed and evaluated with the goal of identification of risk and or gap analysis to determine correctio, systematic changes when indicated, in-service and education with appropriate follow-up and monitoring.Facility policy titled Medication administration, general undated documents in part 5). that medication administration should consist of identifying the resident before administering any /all medications.