STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145821	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Elgin, The	2355 Royal Boulevard Elgin, IL 60123

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer timely and correct treatment for a resident with a UTI (Urinary Tract Infection). The facility also failed to administer medications as ordered by the provider. This failure resulted in R1 being hospitalized for metabolic encephalopathy and UTI due to not receiving the correct antibiotic to treat her UTI. This applies to 3 of 3 residents (R1, R2, and R3) reviewed for UTI in the sample of 5.The findings include:1. R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease, dementia, urinary tract infection, and congestive heart failure. R1's MDS (Minimum Data Set) dated May 30, 2026, showed R1 had severe cognitive impairment. A progress note dated June 1, 2026, at 10:28 PM, by V13 (RN/Registered Nurse) showed Per family member [V11 (R1's family)], resident complained of burning in urination this evening, when resident was asked, replied ?not anymore,' fluids encouraged, physician notified with order to do urinalysis/culture and sensitivity. A progress note dated June 3, 2026, at 8:36 PM, by V7 (NP/Nurse Practitioner) showed Patient is well appearing, she is sitting in dining room. She had positive UA (Urinalysis) and has been started on [nitrofurantoin monohydrate/macrocrystals (antibiotic medication)]. Culture pending. Afebrile, tolerates oral. The EMR did not show an order for nitrofurantoin monohydrate/macrocrystals on or before June 3, 2026. A progress note dated June 4, 2026, at 3:48 PM, by V6 (RN/Registered Nurse) showed UA/CS results were relayed to [V7]/[V8 (R1's Physician)].A progress note dated June 4, 2026, at 11:19 PM, by V5 (LPN/Licensed Practical Nurse) showed UA/CS (Culture and Sensitivity) laboratory results relayed and reviewed by [V10 (Infectious Disease NP)]. New order for ertapenem 1 gram daily intramuscularly injection times five days, diagnosis: UTI. Order carried out.An administration note dated June 5, 2026, at 12:06 AM, by V5 showed [V10] aware. The system has identified a possible drug allergy for the following order: Ertapenem Sodium Injection Solution Reconstituted 1 gram, inject 1 gram intramuscularly one time a day for UTI for five days. An administration note dated June 5, 2026, at 7:10 AM, by V9 (LPN) showed R1's ertapenem sodium 1 gram, was not administered due to, Contraindicated. On June 15, 2026, at 2:34 PM, V6 said on June 4, 2026, she received the urine culture results for R1 and V6 left a message at V8's office and faxed the results to the office. V6 said she did not receive a call back and endorsed the results to the next shift. V6 said when she worked on June 6, 2026, V11 inquired about R1's antibiotic dose. V6 said the antibiotic was not due to be administered to R1 on her shift and V11 requested V6 call the doctor to get a dose administered then. V6 said she called the doctor and received an order to administer a dose of antibiotics at 11:15 AM. V6 said before she called the doctor, R1's first antibiotic was scheduled to be administered June 6 at 5:00 PM. V6 said R1 was sent to the emergency room on June 6, 2026, when R1's granddaughter called emergency medical services due to R1 being lethargic and confused. R1's laboratory results dated [DATE], showed Result called to [V5] June 4, 2026, at 7:13 PM. The results continued to show R1's urine culture had growth of Escherichia coli and positive for ESBL (Extended-Spectrum Beta-Lactamases). The results showed the bacteria was resistant to the antibiotic nitrofurantoin monohydrate/macrocrystals. R1's June 2026 MAR (Medication Administration Record) showed R1 first received an antibiotic on June 6, 2026, (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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	at 11:15 AM. The MAR continued to show the antibiotic was nitrofurantoin monohydrate/macrocrystals. On June 15, 2026, at 3:43 PM, V8 (R1's Physician) said he ordered nitrofurantoin monohydrate/macrocrystals on June 5, 2026, to treat R1's UTI. V8 said he was unaware R1's urine culture and sensitivity results had come back on June 4, 2026, and showed the bacteria was resistant to nitrofurantoin monohydrate/macrocrystals. V8 said if he would have known the culture results, he would not have ordered nitrofurantoin monohydrate/macrocrystals because that antibiotic would not treat R1's UTI. V8 said he was unaware R1 was not administered antibiotics until June 6, 2026, when the nurse called to clarify the order. V8 said it takes about two days of treatment to prevent R1 from experiencing metabolic encephalopathy from a UTI. V8 said R1 was hospitalized with UTI and metabolic encephalopathy. R1's hospital records showed an Emergency Department Attending Physician Note dated June 6, 2026, at 2:47 PM, by V12 (emergency room Physician) showed Chief Complaint: Altered mental status. Patient sent from nursing facility. She does have a history of dementia and is a very poor historian. Majority of history is obtained from nursing facility records. It seems that patient was recently diagnosed with a UTI and started on oral antibiotics. Per daughter she seems to be more lethargic today and more confused than usual. Medical Decision Making: 7:30 PM, Patient resting comfortably. She seems to have some metabolic encephalopathy likely from UTI that has failed outpatient antibiotic treatment. Patient was started on intravenous antibiotics. Case was discussed with [V8] for admission. 2. R2's EMR showed R2 was admitted to the facility on [DATE], with multiple diagnoses including Parkinson's disease, chronic obstructive pulmonary disease, and dementia. R2's infection care plan dated May 15, 2026, showed Resident has a condition requiring antibiotics. Urinary tract infection. The care plan continued to show multiple interventions dated May 16, 2026, including Provide medication per physician orders, monitor for side effects of medication. Vital signs as indicated. An order dated May 23, 2026, showed Meropenem (antibiotic medication) intravenous solution reconstituted 1 gram, use 1 gram intravenously every 8 hours for urine ESBL for 7 days. R2's May 2026 MAR showed R2 was not administered the scheduled meropenem on May 23, 2026, at 10:00 PM, and May 29, 2026, at 10:00 PM. On June 16, 2026, at 2:06 PM, V4 (ADON/Assistant Director of Nursing) said medications should be administered as ordered by the provider. V4 said staff should document administration at the time of administering the medication. V4 said R2's May 2026 MAR does not have documentation to show meropenem was administered at 10:00 PM on May 23 and May 29, 2026. The facility does not have documentation to show R2 was administered meropenem as ordered by the provider at 10:00 PM on May 23 and May 29, 2026. 3. R3's EMR showed R3 was admitted to the facility on [DATE], with multiple diagnoses including cerebral infarction, rhabdomyolysis, and urine retention. R3's UTI care plan dated March 14, 206, showed Resident has a condition requiring antibiotics. Urinary tract infection. The care plan continued to show multiple interventions dated March 14, 2026, including Provide medications per physician orders. Monitor for side effects of medication. Vital signs as indicated. An order dated May 30, 2026, showed ampicillin (antibiotic medication) oral capsule 500 mg (milligram), give one capsule by mouth four times a day for UTI for seven days.R3's June 2026 MAR showed R3 was not administered the scheduled ampicillin on June 2, 2026, at 1:00 PM and 5:00 PM. The MAR continued to show the 1:00 PM dose had documentation to Other/See progress notes. The progress note for R3's June 2, 2026, 1:00 PM ampicillin dose documented by V9 (LPN) showed Doctor aware not available. The facility does not have documentation to show R3 was administered ampicillin on June 2, 2026, at 1:00 PM and at 5:00 PM. On June 16, 2026, at 2:06 PM, V4 said R3's June MAR showed R3 did not receive ampicillin on June 2, 2026, at 1:00 PM and 5:00 PM. V4 said medications should be administered as ordered by the provider. The facility's policy titled Administering Medications dated May 18, 2026, showed Policy Statement: Facility will ensure that medications are administered in a safe and timely manner, and as prescribed. Procedure: .3. Medications are administered in accordance with prescriber orders and medication administration times are determined by facility, resident need and benefit.