STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145980	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of St Charles, The	850 Dunham Rd St Charles, IL 60174

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(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 - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15845 Based on interview, and record review the facility failed to administer antipsychotic drug, sleeping pill, nicotine patch and pain medication as ordered by the physician. The facility also failed to obtain physician order regarding administration of time-critical scheduled medications to ensure doses were evenly spaced to achieve accurate peak and maintain effectiveness. This applies to 12 of 19 residents (R3, R6, R10 through R19) reviewed for medications in the sample of 19. The findings include: The facility roster showed that R3, R6, R10 through R19 were all residing in the XXX unit of the facility. The roster also showed that census of the XXX unit was 27 residents. The staffing schedule of August 1, 2024, for the night shift nurses showed that V5 (Agency Registered Nurse) was assigned to the XXX unit for the night shift. The schedule time for night shift nurses was from 7:00 P.M. through 7:00 A.M. (12-hour shift). The staffing schedule showed that V5 came late at 11:30 P.M. on August 1,2024 P.M. 1. On August 7, 2024, at 10:00 A.M., R3 was in the main dining room. R3 said that her medications were administered to her late at night. R3 thinks it was given to her past 10:00 P.M., Thursday night of last week (August 1, 2024). R3 said her medications were for her blood pressure, and nerve pain. The POS (Physician Order Sheet) for the month of August 2024 showed that R3, an [AGE] year-old with diagnoses of cerebral infarction, atrial fibrillation, hypertension, pathologic fracture, and AHSD (atherosclerotic heart disease). The POS (Physician Order Sheet) also showed physician order for the following medications: -Eliquis 5 mg. (anticoagulant) 1 tablet 2 times a day for DVT prophylaxis -Gabapentin 300 mg. 1 capsule three times a day for pain. The EMAR (Electronic Medication Administration Record) for August 1st to 7th of 2024 showed that there was no documentation of time when these medications were administered to R3. The EMAR only showed MP A; MP E; MP N. (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 - Some	On August 7,2024 at 4:00 P.M., V2 (Director of Nursing) explained that MP A is medication pass afternoon; MP E is medication pass for early morning and or evening, and MP N is medication pass night. V2 explained the early morning is 4:00 A.M through 6:00 A.M.; afternoon is 12:00 Noon through 2:00 P.M.; evening it's confusing I don't know the time since there is already the MP E which is early morning: and MP N is 7:00 P. M. through 10:00 P.M. V2 added that besides these hours of administration, nurses can administer medications an hour early and hour after the time of the mentioned time. V2 had acknowledged that the EMAR does not show the hour the medication was administered, and thus, it opens the opportunity for uneven spacing of medication dose. V2 validated that due to undetermined time that the medication was administered, the possibility of first and second dose of three times a day medication order will be 12 hours gap time and third dose will be within 3 hours from the second dose. V2 added that this makes it uneven spacing of doses for medication administration. V2 added that with R3's case of Gabapentin medication, there was no way of telling the time when the medication was given in afternoon, evening, and night. On August 7,2024 at 1:57 P.M., V7 (Registered Nurse/RN) said that on August 1,2024, V5 came in late around 11:30 P.M. V7 said she tried to help administer medications to residents in the XXX unit at 10:30 P. M. when she was done in her assigned unit. V7 said that together with V8 (RN) they started passing medications. However, V7 said that they were not able to pass all medications that needed to be passed in the XXX Unit and that they waited for V5 to pass the remaining medications. On August 7, 2024, at 3:30 P.M., V5 (Agency RN) said she had arrived at the facility at 11:30 P.M. on August 1,2024. V5 said that there were approximately 6 residents left that were not given their night medication that were customarily given between 8:00 P.M. through 10:00 P.M. because V7 and V8 were not able to complete the medication pass in the XXX unit. 2. On August 7, 2024, at 2:15 P.M., R6 was in the hallway. R6 said they always give my medication late at night. It does not help with my pain, my spasms, and my blood pressure. The nurses gave my night medications late and just have a long space gap in between my medications from day and night. It had happened again sometime last week when the nurse showed up late, I think it was Thursday (August 1, 2024). The POS for the month of August 2024 showed that R6, a [AGE] year-old with diagnoses of cerebral infarction, diabetes mellitus, hypertension, and peripheral neuropathy. The POS also showed physician order for the following medications: -Neurontin 600 mg. QID (4 times a day) for neuropathy pain -Coreg 25 mg. 1 tablet BID (2 times a day) for hypertension -Baclofen 15 mg. TID (3 times a day) for pain -Hydralazine HCL 50 mg. 1 tablet TID for hypertension The EMAR (Electronic Medication Administration Record) for August 1st through 7th of 2024 showed there was no documentation of time when these medications were given to R6. The EMAR only showed MP E; MP A; MP E; MP N. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On August 7, 2024, at 5:00 P.M., R10 was in her room. R10 said in an angry tone of voice they always give my medication late at night. It does not help with my pain, my blood pressure going so high and very unstable, it even went up to 200 and I am usually 130 to 140. There was a long gap/space time when they give my medications. It had happened again last Thursday (August 1,2024 at nighttime), my medications were given to me late and there was a long gap when I last took it. The POS for the month of August 2024 showed that R10, a [AGE] year-old with diagnoses of delayed healing of fracture of the right foot, polyneuropathy, anxiety disorder, major depression, hypertension, epilepticus, chronic pain syndrome, and diabetes mellitus type 2. The POS also showed physician order for the following medications: -Insulin Glargine 25 units subcutaneously one time a day for diabetes mellitus -Neurontin 600 mg. QID (4 times a day) for neuropathy pain -Duloxetine 30 mg. 1 capsule BID for depression -Hydralazine 25 mg. 1 tablet BID for hypertension -Hydroxine HCL 25 mg. 1 tablet BID for anxiety -Ativan 1 mg. 1 tablet TID for anxiety. The Ativan order was scheduled to be given 9:00 P.M. for the night shift. -Metoprolol Tartrate 50 mg. BID for hypertension -Voltaren gel 1%; apply to hands topically BID for pain of hands and fingers -Gabapentin 400 mg. 400 mg. QID for pain The EMAR (Electronic Medication Administration Record) for dated August 1st through 7th of 2024, showed there was no documentation of time when these medications were given to R10. The EMAR only showed MP E; MP A; MP E; MP N. The EMAR also showed that R10's Insulin Glargine scheduled as MP N was signed by V5. There was no documentation of time when it was given. Since no time documentation of insulin administration, it was undetermined if the insulin was administered as ordered by the physician. V5 also signed the Voltaren was applied, but no time was documented. The Ativan that was scheduled to be given at 9:00 P.M. was not given until past 10:30 P.M. V7 (RN) signed that it was given, but no time documented. V7 stated she came to administer medication to XXX unit at around 10:30 P.M. 4. On August 7, 2024, at 2:45 P.M., R11 was in bed. R11 did not response when asked about his medications. The POS for the month of August 2024 showed that R11 was [AGE] year-old with diagnoses of unspecified dementia epilepsy, malignant neoplasm of the nerve, anxiety disorder, major depressive disorder, and unspecified psychosis. The POS (Physician Order Sheet) also showed physician order for the following medications: -Risperdal 0.5 mg. 1 tab BID for psychosis -Baclofen 15 mg. TID for spasticity (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Melatonin 5 mg. 1 time a day for insomnia to be given at 9:00 P.M. The EMAR (Electronic Medication Administration Record) for August 1st to 7th of 2024 showed there was no documentation of time when these medications were given to R11. The EMAR only showed MP E; MP A; MP E; MP N. The Melatonin that was prescribed to be given at 9:00 P.M. was given by V5 (Agency RN), signed as given at 9:00 P.M. V2 (DON) when interviewed on August 7, 2024, at 4:00 P.M., said that there was no explanation how V5 was able to sign R11's sleeping pill at 9:00 P.M. wherein in fact V5 came in at 11:30 P.M. V2 said she cannot explain how the EMAR system works for documentation not knowing what time the medication was given. 5. On August 7, 2024, at 5:15 P.M., R12 was in the hallway of XXX unit. R12 said they always give my medication late during the night. It does not help with my pain, and my blood pressure was very unstable. The nurses gave my medication late at night and the spacing of medications doses were either long or short gap time for administration. It was very late when my medications were given last Thursday, August 1,2024 because the night nurse was late, and other nurses tried to help but they also have other residents to attend to. The POS for the month of August 2024 showed that R12, [AGE] year-old with diagnoses of diabetes mellitus type 2, end stage renal disease, anxiety disorder, hypertension, and osteoarthritis. The POS also showed physician order for the following medications: -Metoprolol Succinate 50 mg. 1 tablet BID for hypertension -Gabapentin 300 mg. 1 capsule BID on Tuesdays/Thursdays/Saturdays for nerve pain The EMAR for August 1st to 7th of 2024 showed there was no documentation of time when these medications were given to R12. The EMAR only showed MP E; MP A; MP E; MP N. 6. On August 7, 2024, at 5:20 P.M. R13 was in the hallway of XXX unit. R13 said they always give my medication late during the night. Sometimes I have to wait for short or long time until my next dose. I take medication for my pain, and I need to have it on time. The POS for the month of August 2024 showed that R13, a [AGE] year-old with diagnoses of malignant neoplasm of prostate and pancreas, and pain related to the neoplasm. The POS also showed physician order for the following medications: -Gabapentin 600 mg. 1 capsule TID for pain -Cyclobenzaprine HCL 10 mg. TID for muscle spasm The EMAR dated August 1st to 7th of 2024 showed there was no documentation of time when these medications were given to R13. The EMAR only showed MP E; MP A; MP E; MP N. 7. On August 7, 2024, at 5:30 P.M. R14 was in the hallway of XXX unit. R14 said she does not understand her medication administration. R14 said that said that sometimes her medications were given late at night. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDS (Minimum Data Set) dated 7/18/2024 showed R14's BIMS (Brief Interview Mental Status) score of 14/15 (cognitively intact). The POS for the month of August 2024 showed that R14, a [AGE] year-old with diagnoses of cerebral infarction, vascular dementia for agitation, hypertension, chronic kidney disease, and diabetes mellitus type 2. The POS also showed physician order for the following medications: -Hydralazine HCL 2 tablets for hypertension and was scheduled to be given every 8 hours at 6:00 A.M.: 2:00 P.M. and 10:00 P.M. -Risperdal 0.5 mg. 1 tablet BID for agitation -Nicotine Patch 14/24 hour; apply 1 patch transdermal on in a day for smoking cessation, remove per schedule; remove at 8:59 P.M.; apply a new on at 9:00 P.M. The EMAR of for August 1st to 7th of 2024 showed that on August 1st of 2024, V5 (Agency RN) had signed that she removed the Nicotine Patch at 8:59 P.M., applied a new one at 9:00 P.M., V5 administered Hydralazine at 10:00 P.M., and Risperdal with MP N V5 signed it was given but no documented time when it was administered for the antipsychotic medication (Risperdal). Again, this concern was discussed with V2 how V5 can signed on those times if she was not in the facility. 8. The POS for the month of August 2024 showed that R15, an [AGE] year-old with diagnoses of kidney failure, low back pain, peripheral vascular disease. The POS also showed physician order for the following medications: -Tramadol 50 mg. 1 tablet BID for pain -Gabapentin 100 mg. 2 capsules TID for neuropathy The EMAR for August 1st to 7th of 2024 showed that there was no documentation of time when these medications were given to R15. The EMAR only showed MP E; MP A; MP E; MP N. 9. The POS for the month of August 2024 showed that R16, a [AGE] year-old with diagnosis that include but not limited to depressive disorder. The POS also showed physician order for R16: -Mirtazapine 15 mg. for depression; 1 tablet to be given at bedtime at 9:00 P.M. The EMAR showed that V5 had signed at 9:00 P.M. on August 1st, 2024, that R16's Mirtazapine was given. This was discussed again with V2 (DON), regarding the explanation of V5 signing at 9:00 P.M. and that V5 was in at 11:30 P.M. 10. The POS for the month of August 2024, showed that R17, a [AGE] year-old with diagnoses of epilepsy, neoplasm of brain, right and left breasts, hypertension and disease of nervous system and sense organs. The POS also showed a physician order for: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Alprazolam 1 TID for anxiety -Clonidine 0.1 mg, for hypertension, Gabapentin 900 mg. TID for nerve pain The EMAR for August 1st to 7th of 2024 showed there was no documentation of time when these medications were given to R17. The EMAR only showed MP E; MP A; MP E; MP N. 11. The POS for the month of August 2024, showed that R18, a 92-atrial fibrillation, cerebral infarction, and hypertension. The POS also showed a physician order for: -Eliquis 5 mg. 1 tablet BID, an anticoagulant related to personal history of cerebral infarction. The EMAR for August 1st to 7th of 2024 showed there was no documentation of time when the anticoagulant was given to R18. The EMAR only showed MP A, MP N. 12. The POS for the month of August 2024, showed that R19, [AGE] year-old with diagnosis that includes but not limited to COPD (chronic obstructive pulmonary disease). The POS also showed a physician order for: -Symbicort Inhalation Aerosol 1 puff BID for COPD (an inhaler that maintains and prevent airflow obstruction in patients with COPD). The EMAR for August 1st to 7th of 2024 showed there was no documentation of time when the inhaler was given to R19. The EMAR only showed MP E, MP N. On August 7, 2024, at 5:45 P.M., V9 (Medical Director) said that physician order should be obtained if agreeable with Resident-Centered administration of medication. V9 also said that there an opportunity of error and was not a safe practice to administer medication with spacing of medication doses that were not evenly distributed with time of administration. V9 added this uneven spacing can cause a significant adverse effect to residents to include metabolism of the drug that might also affect kidneys. V9 added medications that require timely administration and even space of medication doses needed to have the time spelled for administration. V9 further said that medications included but not limited to hypertensive medications, pain medications, and most medications except vitamins and supplement should be timely scheduled with even spacing of doses administration. On August 8, 2024, at 9:00 A.M., V10 (Nurse Practitioner) also said it is a standard of practice for medication administration to evenly space the medication dosage by making sure the time was spelled out and it will not be ambiguous to implement. V10 also said that medications being administered with properly timed spacing of doses will result to maximum benefit of such medications and prevent significant adverse outcome. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The policy for Resident -Centered Medication Administration dated 3/29/2024 showed DEFINITIONS: Time-Critical Scheduled Medications: is a medication where early or delayed administration of maintenance doses of greater than 30 minutes before or after the scheduled dose may cause harm or result in substantial sub-optimal therapy or pharmacologic effect .PROCEDURE .3. Obtain an order from each resident's provider that she/he may participate in the resident-centered medication administration and enter each order into each resident's medical record and care plan .6. This resident centered medication administration policy will exclude and not apply to the following medication categories . a. Time-Critical Scheduled Medications, include the following: 1. Medications with a dosing schedule more than every 4 hours .f. Drugs administered at specific time doses to ensure accurate peak/serum drug levels re achieve and maintained. The residents' mentioned above (R3, R6, R10, R11, through R19) EMR, POS, CP (care plan) showed that there were no orders obtained from their physicians for resident-centered medications administration.