

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145980	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Pearl of St Charles, The		STREET ADDRESS, CITY, STATE, ZIP CODE 850 Dunham Rd St Charles, IL 60174	

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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on interview and record review, the facility failed to ensure a resident was free from significant medication error for 1 of 10 residents (R1) reviewed for medication errors. The findings include: R1's face sheet documents diagnoses which include fracture of left calcaneus with delayed healing, fracture of first metatarsal bone, left foot, fractured shaft of left tibia, displaced fracture of left acetabulum, fractured shaft of left fibula, fractured left pubis and fractured left ileum due to motorcycle driver injury. R1 also with diagnoses of anemia, intestinal obstruction, and hypertension. R1's MDS (Minimum Data Sheet) dated 12/28/25 documents he has intact cognitive functions. On 1/6/26 at 11:00 AM, R1 said on October 19, 2025, around midnight, V17 (Registered Nurse/RN) administered the wrong IV (Intravascular) medication. He said after the medication was infused, he noticed that the medication had a different resident's name. He said he informed the nurse immediately. On 1/6/26 at between 11:20 AM and 12:00 PM, separate interviews with V7 (RN) and V9 (RN/Unit Manager) said that V17 gave R1 the wrong IV medication on 10/19/25. They said R1 had an order for Vancomycin but V7 administered Zosyn instead. R1's October 2025 POS (Physician Order Sheet) documents order for Vancomycin Hcl in Dextrose Solution 1 gram/200 ml, use 1.75 mg three times a day to start on 10/11/25 until 10/20/25 for bacterial wound infection. R1's Progress Notes dated 10/19/25 documents a medication error happened. Piperacillin/Tazobactam 3.375 grams 100 ml was administered to R1 instead of the ordered Vancomycin. On 10/7/26 at 11:30 AM, V2 (Director of Nursing) said she expects her nurses to confirm the five Rs of medication administration (right patient, right drug, right dose, right route and right time) prior to administering meds to make sure they are giving correct medication to correct resident at the right time to prevent harm from giving wrong medication. Facility Medication Administration Policy and Procedure dated 3/20/2020 and reviewed on 4/15/2025 documents the following: Intent: All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. Guideline: 5. Check medication administration record prior to administering medication for the right medication, dose, route, patient and time. 15. Identify resident using two resident identifiers.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 145980	If continuation sheet Page 1 of 1